State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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1.4 Overview of the State

Geography

Unique Characteristics

The state of Rhode Island is a small (1,055 square miles), coastal area of just under one million residents (990,819). The entire state measures just 48 miles, from north to south, and 37 miles, from east to west. The overwhelming majority of Rhode Islanders are White (92.6%), and they are mainly the descendents of European immigrants who were attracted to the state's textile and jewelry industries many years ago. Historically, long established African American families and members of the small Native American Narragansett tribe made up most of the state's minority population. However, in recent years, representatives of other groups (e.g. Hispanics and Asians) have been increasing due to recent immigration patterns. A combination of cultural, socio-economic, and transportation-related factors has caused "the neighborhood" to become the most important level of community for many of the state's low-income residents.

Population Spread

Eighty-six percent (86%) of Rhode Island's population resides in urban areas, which ranks the state seventh in the nation in this respect. Rhode Island is also the second most densely populated state in the nation, with 960 residents per square mile. Although about two-thirds of the state's surface area is relatively "rural" in character, most of its population is concentrated in the northeastern part of the state. The Capitol City of Rhode Island, Providence, is a major metropolitan community, in which more than 160,000 residents reside.

Special Issues Impacting Health Services & Programs

Rhode Island is an attractive setting for public health program implementation, given its small geographical size and unique governmental structure. Even the most "remote" parts of the state are less than an hour's drive from the capitol. In addition to two congressional districts, the state is made up of 39 cities and towns ranging from 1.3 to 64.8 square miles in size. In Rhode Island, local communities possess control in areas such as primary and secondary education, subdivision of land and zoning, and housing code enforcement. There is no county level of government in Rhode Island, with the exception of the state court system. The sole public health authority in the state is the Rhode Island Department of Health (HEALTH). The absence of local health authorities means that health care providers in the state look to HEALTH for policy guidance and other forms of assistance.

Demographics

Population Characteristics

About one quarter of the state's population (216,350) are women of childbearing age (15-44 years). Another one quarter of the population (241,180) is made up of children under 18 years old. Children under age 18 are significantly more diverse in racial and ethnic backgrounds than the adult population. 88.5% of Rhode Island's children are White, 7.2% are African American, 3.4% are Asian, and less than 1% are Native American. 10.3% are Hispanic.

About 29% of Rhode Island's children live in single parent families. Just under half (46%) of Rhode Island's single parent families live below poverty, compared to 4% of two parent families with children. Seventy percent (70%) of children living below poverty in Rhode Island lived with a single mother. In 1997, there were

39,140 (18%) poor children in Rhode Island. This is an increase from the 1990 Census figure when 14% of the state's children lived in poverty. Most of the state's poor children are White (73%). However, Hispanic children were included in any one of the race categories. Of the state's 39,140 poor children in 1997, 26% were Hispanic, 16% were African American, 6% were Asian, and 2% were Native American.

Racial Ethnic Breakdown

Presently, Hispanics are the largest and most rapidly growing segment of the state's minority population, now representing almost 6% of the state's total population. In 1970, there were about 8,000 Hispanics in the state. In 1996, there were more than 59,000 and this number is expected to grow to 70,000 by the year 2000. Noticeably younger than the average Rhode Islander, the median age of Hispanics in Rhode Island is 25 years. Although there are small groups of Hispanics living in just about every community in the state, four out of five are concentrated in the older, urban cities of Providence, Pawtucket, Central Falls, and Cranston. About 37% of Hispanics in Rhode Island report that they speak English poorly or not at all.

The second largest minority group, African Americans, have been established in Rhode Island for many years, and they presently comprise 4.8% of the state's population (about 47,000 individuals). Over 11% of blacks in the state are Latino, a large majority of whom came from the Dominican Republic. Nearly 99% of African Americans live in urban areas, mainly Providence, Woonsocket, Pawtucket, Newport, or East Providence.

Asians represent 2.2% of the state's total population (about 21,300 individuals, with Cambodians, Hmong, Laotians, Thai, and Vietnamese representing 44% of the state's Asian grouping). Many Asians immigrated to Rhode Island during the late 1970s and 1980s from the war torn countries of Vietnam and Cambodia. About 93% of Asians in Rhode Island live in the older, urban communities of Providence, Woonsocket, and Cranston. Approximately 84% of Asians over the age of five speak a language other than English in the home.

Native Americans presently make up 0.5% of the state's population (about 4,600 individuals) and most live in Providence, Narragansett, North Kingstown, and Charlestown. The population consists primarily of members of the Narragansett Tribe, but there are also many urban Native Americans who originate from other tribes throughout the United States. The median age of the Native-American population is 27.9 years of age.

Immigration Patterns

Immigration is an important source of population growth in Rhode Island. For the period 1990-1994, about 6,000 individuals immigrated to Rhode Island. Many of these people are Hispanic. The majority of Hispanics in Rhode Island come from Puerto Rico, the Dominican Republic, and Columbia. In addition, Rhode Island has a significant number of undocumented individuals. According to the U.S. Immigration and Naturalization Services, there were 6,000 to 9,900 undocumented individuals living in Rhode Island in 1992. This figure represents one-half to one percent of the state's total population. It is also estimated that nearly 2,600 Latino Rhode Islanders were not counted in the 1990 Census.

Population Trends & Future Projections

In 1990, Rhode Island's total population reached an all time high of 1,003,464 residents. However, the economic recession in the early 1990s caused many Rhode Islanders to leave the state in search of better opportunities. In fact, Rhode Island experienced a greater permanent flight of its people than any other state during

the national recession. By the end of 1995, roughly 45,000 people left and Rhode Island was one of only two states to experience a population decline from 1990-1998. Rhode Island' population fell by 1.5% during this period and by 2010, the state is expected to grow by only 2.8%. However, the working age group in Rhode Island (16-64 years) is expected to grow by only a modest 5.4% between 1995 and 2010. Over the next decade, the number of Rhode Island teenagers will grow by about 20% while the number of younger children from birth to 12 years of age will drop by 2%.

In addition, Rhode Island will continue to become more ethnically and racially diverse during this century. The state's racial and ethnic minority populations are undergoing a very rapid growth rate, especially in the state's urban, core communities. According to Census 2000 projections, African Americans in Rhode Island will increase by 38%, Asians by 55%, and Hispanics by 65%. Between 1995 and 2005, the number of White, Non-Hispanic children is expected to decrease by 7%, while the number of Black, Hispanic, Asian, and Native American children will increase by 43%.

Current Socioeconomic Indicators and Racial and Ethnic Health Disparities by Population

In Rhode Island, the health disparities experienced by the poor and racial and ethnic minorities have been well documented. In general, Rhode Island's racial and ethnic minorities are more likely to be poor, uninsured for health care, and unemployed. Racial and ethnic health disparities in Rhode Island are discussed in more detail in the needs assessment section of this application (See Page 77).

State Based Issues Impacting on Women and Children

Current Economic & Political Climate

Historically well paid and well insured for health care through the presence of a strong manufacturing base, Rhode Island experienced the worst economic recession since the Great Depression in the 1990s. Since 1989, it lost 11.6% of its total job base. Although most economists agree that the state (and the nation) has been in a strong economic expansion since then, payroll employment growth in Rhode Island still ranked 35th and its labor force employment growth ranked 41st among the 50 states in March of 2000. During the same period, the unemployment rate in the state was 3.7%, which ranked the state 25th in the nation in this respect. Although the expansion has improved the quality of life of many Rhode Islanders, it is clear that many Rhode Islanders have not fared well at all.

Welfare Reform

The Family Independence Program (FIP) is the state's welfare reform program, as set forth in the Rhode Island Family Independence Act of 1996. The FIP seeks to help low-income families by providing the supports, including subsidized health insurance, childcare, and work-readiness activities, that families need in order to obtain and keep a job. Under the FIP, adults can receive cash assistance up to a time limit of five years in their lifetime. In Rhode Island, children are not subject to a time limit on cash assistance. As of December 1, 1999, 49,465 adults and children were enrolled in Rhode Island's FIP. 33,256 of these individuals were children.

New Emerging Statewide Programs

Beginning this year, Rhode Island is implementing a comprehensive child care and early education program designed to expand its early and school age child care subsidy to include more working families, to increase options available to those families, and to improve the quality of care provided to children. Called Starting

Right, this innovative initiative will make Rhode Island one of the nation's most progressive states in the critical area of early childcare and education. Administered by the Rhode Island Department of Human Services (DHS), Starting Right includes a component that will expand the existing state childcare subsidy program to include age-appropriate activities for adolescent children ages 13-16 during after-school hours. The initiative is also preventive in nature, in that it provides a strategy for addressing the increasing problems of juvenile crime, violence, and teen pregnancy.

Another important emerging initiative is DHS's planned Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Re-evaluation (CEDARR) initiative for children with special health care needs (CSHCN). Through this initiative, DHS will define a statewide set of services that will assure timely access to appropriate, high quality, coordinated services for CSHCN and their families. DHS will purchase services through certified providers and services will be provided through "centers for excellence" called CEDDAR Family Centers. The services available through CEDDAR Family Centers are expected to significantly enhance the range and quality of services available to CSHCN and their families in Rhode Island.

Health Insurance Status

Uninsured By Population

Rhode Island is experiencing a pattern of deteriorating private health insurance coverage. Despite recent expansions in the state's Medicaid managed care program, 10.7% of Rhode Island's population remains uninsured for health care. This percentage has increased among adults in recent years. The highest rates of uninsured adults fall into the "working poor" category. Residents belonging to minority groups have been especially hard hit by this changing trend. For the period, 1994-1995, minority adults were between two and four times as likely to be uninsured as White, Non-Hispanic adults in Rhode Island. Large increases occurred in groups in which there has been substantial immigration since 1990, and underscores the difficulties that newly arriving immigrants face in accessing health care services in the state. Despite recent expansion of RIte Care to include children, about 5,040 children under age 19 years of age remain ineligible because their family income is greater than 250% of poverty. Almost three-quarters of Rhode Island's uninsured children live in working families.

Medicaid Managed Care & CHIP Enrollment

The state's Medicaid managed care program, RIte Care, has had a profound impact on the state's health care system. Recently, coverage under RIte Care was expanded through the federal Children's Health Insurance Program (CHIP) to include children up to age 18 (and 19 if still in school) if their family income is less than 250% of poverty. In addition, a new state law requires RIte Care to cover immigrant children whose parents are in the country illegally. It is estimated that 15,000-20,000 children are eligible for RIte Care, but remain un-enrolled. State law also expanded eligibility to include pregnant women up to 350% of poverty; the parents of children with a family income up to 185% of poverty, and child care providers who serve low-income children. Initially, about 85,000 individuals were covered by RIte Care. By July 2000, RIte Care increased the number of previously uninsured enrollees from to 108,000, up from 101,000 just two months before.

Next year, the number of people enrolled in RIte Care is expected to grow by another 20,500, to a total of about 128,500. Unfortunately, there is evidence that up to 20,000 Rhode Islanders left their more costly private

health insurance plan to enroll in RIte Care during 1999/2000. The rapid increase in the RIte Care caseload has caused the state Department of Human Services to predict a combined shortfall of $46.3 million for fiscal years 2000 and 2001. In July of 2000, the state's House of Representatives approved a plan to slow RIte Care's growth in enrollment and support employer-based coverage. The Senate is expected approve this plan in the near future (See Page 207).

Managed Care & Its Stability

Rhode Island's health care environment is characterized by medium to medium-high managed care penetration. For residents with health care coverage (excluding Medicare and Non-RIte Care Medicaid), almost all residents receive care through an HMO, PPO, or other managed care arrangement, including RIte Care. Last year, two of the state's largest private health insurers, Harvard Pilgrim & Tufts, stopped doing business in Rhode Island. The two remaining insurers, Blue Cross and United Health Plans, significantly increased their rates. The number of uninsured individuals in Rhode Island has increased, in part because premiums are beyond the reach of many individuals and employers. Many of these uninsured individuals continue to turn to RIte Care for coverage.

Statewide Health Care Delivery Systems

Rhode Island has a long tradition of public investment in health services, with special attention to pregnant women, infants, and children with special health care needs (CSHCN). A well-distributed mix of private practitioners, multi-specialty groups, and a statewide network of community health centers and hospital-based primary care clinics provide health care. Tertiary perinatal and pediatric centers in Providence back up the state's 8 acute care hospitals. The majority of very low birthweight infants in Rhode Island (93.4%) are delivered at Women & Infants Hospital, which is the regional perinatal center. Although Rhode Island hosts a large health care workforce relative to its population, primary care access remains a problem among the state's most vulnerable residents. The urban communities of Providence, Woonsocket, Pawtucket, Central Falls, and Newport have been designated Health Professional Shortage Areas (HPSAs) by the federal Bureau of Primary Health Care (BPHC). By definition, those who live in a Rhode Island HPSA are at greater risk to lack access to primary care.

About one-half of Rhode Islanders have dental insurance coverage, which includes 144,000 individuals with Medicaid. Although Rhode Island has one of the highest Medicaid dental utilization rates at 33%, two-thirds are not utilizing dental services. State law requires that children in kindergarten through sixth grade receive yearly dental examinations. However, fewer than half of CSHCN in Rhode Island receives dental care.

Publicly-funded mental health services for children in Rhode Island are provided by the state Department of Children, Youth, and Families (DCYF) through contracts with community-based organizations and mental health care for adults is provided by the state Department of Mental Health, Retardation, & Hospitals (MHRH) directly or through RIte Care. Annually, more than 6,000 RIte Care enrollees receive mental health services through their plan. Low-income, uninsured individuals are dependent upon the state's community mental health system for services. Children's mental health remains significantly under-funded in Rhode Island. However, DCYF is currently in the process of examining the funding gaps in the service delivery system for children (including CSHCN) who have emotional, behavioral, or mental health concerns through the statewide Project Reach Initiative.

Title V Role in the State Public Health System and MCH Priorities

See page 150 & Form 14 for a list of the State's MCH priorities.

The Rhode Island Department of Health's Division of Family Health (DFH) has primary responsibility for assessing the health and developmental needs of young families and children in the state, for planning effective measures to address those needs, for evaluating programs and policies affecting the health and development of children, and for the management of maternal and child health programs providing services to women and children through community-based agencies. The DFH identified these 10 priorities from a longer list through a comprehensive strategic planning process. The DFH's strategic planning process is one that relies on data collection and surveillance, parent and community input, and interagency collaboration. The DFH's community input is gathered from community meetings, a public hearing, and parent surveys. All of these priorities relate to the state's plans for Healthy People 2010 objectives.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

As the recipient of the state's federal Title V Maternal & Child Health (MCH) block grant funds, the DFH plays an important role in addressing the state's public health needs. The DFH utilizes its MCH funds to, among other things, conduct outreach activities to enhance Medicaid enrollment and to improve access to preventive and primary care health services for women and children, including children with special health care needs. Under the overarching umbrella that makes up its Title V priorities, the DFH assures that all Rhode Islanders, especially those who are under-served, have access to a full array of comprehensive, quality, health care services.

The DFH is a major component of HEALTH, which is a cabinet agency that directly reports to the Governor. The DFH is organized into five sections: The Office of Children's Preventive Health Services (CPHS), the Office for Children with Special Health Care Needs (CSHCN), the Adolescent & Young Adult Health (AYA) Unit, the Office of Women, Infants, & Children (WIC), and the Office of the Medical Director. The DFH has a Medical Director, an Assistant Medical Director, parent leadership, appropriate chiefs and program managers, and senior staff responsible for management, data and evaluation, policy, and communications. The only change to the DFH's existing MCH organizational structure over the past year involves the DFH's Parent Consultant Program. The DFH is in the process of issuing a new RFP for the Parent Consultant Program, which is expected to be in place by September of 2000. At that time, the DFH will be able to recruit and support new parent consultants to replace those who have left for other employment opportunities.

See Supporting Documents Section (Page 207) for State Government Organizational Chart relating Title V to the Governor.

See Supporting Documents Section (Page 207) for State Health Agency Organizational Chart.

See Supporting Documents Section (Page 207) for State Title V Organizational Chart.

See Figure 1 on page 10 for relevant state statutes and dates.

FIGURE 1
LIST OF RELEVANT STATUTES & DATES

CHAPTER 11-9-13	Illegal Sale of Tobacco Products To Children (1996 &1999)
CHAPTER 16-21-7	School Health Programs (1938 & 1996)
CHAPTER 16-21-9	School Health Examinations & Dental Screenings (1911 & 1998)
CHAPTER 16-21-14	School Hearing, Speech, & Vision Examinations (1956 &1996)
CHAPTER 16-24	Education for Children with Disabilities (1952 &1996)
CHAPTER 23-1-18	Testing for Communicable Diseases for Pre-School Aged Children (1966 &1993)
CHAPTER 23-1-18	Childhood Immunization Registry For Persons Under Age 18 (1966 & 1993)
CHAPTER 23-1-36	Health Education, Alcohol and Substance Abuse Programs for Students (1986 &1996)
CHAPTER 23-13	Maternal & Child Health Services (1937 &1999)
CHAPTER 23-13-14	Newborn Metabolic Disease Program (1987 &1995)
CHAPTER 23-13-15	Newborn Sickle Cell Disease Program (1987 & 1995)
CHAPTER 23-13-17	Women, Infants, & Children (WIC) Program (1987 & 1996)
CHAPTER 23-13-20	Family Life Act (1988)
CHAPTER 23-13-22	Early Intervention (1991)
CHAPTER 23-17.7	Health Care Quality Program (1991)
CHAPTER 23-20.9-3	Tobacco Free School Environment (1992)
CHAPTER 23-24.6	Childhood Lead Poisoning Prevention Act (1991)
CHAPTER 23-64	Minority Health Promotion Act (1992)
CHAPTER 27-38.12	Insurance Coverage for Pediatric Preventive Care (1988)
CHAPTER 31-22-22	Child Restraint-Safety Belt Use (1980 & 1988)
CHAPTER 37.3	Confidentiality of Health Care Information Act (1978)
CHAPTER 40-5.1	Family Independence Act (1996)
CHAPTER 40-6	Public Assistance Act (1987 & 1998)
CHAPTER 40.6.2	Child Care – State Subsidies (Starting Right – 1998)
CHAPTER 40-8	Medical Assistance (1966 & 1999)
CHAPTER 40-8.4	Health Care for Families (RIte Care Expansion-1998)
CHAPTER 40-11	Abused & Neglected Children - Duty to Report (1976 & 1999)
CHAPTER 40-19	Comprehensive Adolescent Pregnancy & Parenting Program (1991)
CHAPTER 40-19.1	Teen Pregnancy Prevention Partnership (1997)
CHAPTER 42-12-8	Traumatic Brain Injury (1985) & Spinal Cord Injury (1997) Registry
CHAPTER 42-12.3	Health Care Act For Children & Pregnant Women (RIte Care-1993)

1.5.1.2 Program Capacity

See Tables 1, 2, and 3, which start on page 11, for State Title V funded programs with descriptions.

TABLE 1

Title V Funded Preventive and Primary Care Services/Programs for Pregnant Women, Mothers and Infants	
Program	**Description**
Breastfeeding Media Campaign	Administered by the Division of Family Health's (DFH's) WIC Program in collaboration with the DFH's Communications Unit, the Breast-Feeding Media Campaign promotes breastfeeding as a healthy alternative to formula feeding. The Campaign primarily targets low-income pregnant women and mothers with infants living in racially/ethnically diverse communities.
Communications Unit	Housed in the DFH, the Communications Unit develops and implements culturally competent health communications campaigns to improve child and family health throughout the state. The Unit serves the DFH's entire targeted maternal & child health population, which primarily target low-income families with children living in racially/ethnically diverse communities and CSHCN.
Child Opportunity Zone (COZ)/Starting Points Initiatives	The DFH provides Title V funding to the Rhode Island Department of Education to support the 13 school-linked COZ sites located throughout the state. Most of the state's COZ sites are located in racially/ethnically diverse urban communities. In addition, the DFH, in collaboration with the Rhode Island Departments of Human Services (DHS) & Education, the United Way of Southeastern New England, and RI KIDS COUNT, funds 9 Starting Points COZ Family Centers to provide culturally competent, school-linked early childhood services to families with children ages birth to five living in racially/ethnically diverse urban communities. Rhode Island is one of 11 Starting Points sites in the nation funded by the Carnegie Corporation of New York.
Chlamydia Project	Title X Region I provides funding to the Rhode Island Department of Health's (HEALTH's) Office of Sexually Transmitted Diseases (STDS) to reduce the prevalence of Chlamydia in women at risk, including adolescents. The Office of STDs funds the DFH's largest family planning clinic and one School-Based Health Center (SBHC) to provide culturally competent Chlamydia screening, education, and treatment services to women in 2 racially/ethnically diverse urban communities.
Family Resource Counselor (FRC) Program	The DFH contracts with 13 community health centers and 3 hospital-based clinics to employ culturally diverse FRCs to conduct outreach and referral to families potentially eligible for RIte Care, WIC, and other community-based support services. The FRC Program primarily serves low-income families living in racially/ethnically diverse communities.
Farmers Market Nutrition Program (FMNP)	The DFH provides low-income families and children enrolled in WIC with access to nutritious fresh foods through the culturally competent FMNP. Significant proportions of the families that are served by WIC live in racially/ethnically diverse communities.
Disabilities & Health Program	Located in the DFH, the Disabilities & Health Program promotes access to care for individuals with disabilities through the implementation of population-based activities. The Program serves adults and CSHCN throughout the state.
Family Planning Program	The DFH contracts with 11 culturally competent family planning clinics to provide direct family planning services to individuals. The Program primarily serves low-income women and adolescents throughout the state. A significant proportion of the women and adolescents served through the Family Planning Program live in racially/ethnically diverse communities.
Genetics Program	Housed in the DFH, the Genetics Program develops policies and programs designed to increase individuals' access to genetics services. The Program is funded through a HRSA Genetics Grant and serves the state's entire population, including CSHCN.
Healthy Child Care	Located in the DFH, Healthy Child Care develops policies and programs designed to promote the health and safety of children in childcare (including adolescents) through

	culturally appropriate infrastructure building activities, training and technical assistance, and collaboration with other agencies. Healthy Child Care primarily targets low-income families with children living in racially/ethnically diverse urban communities & CSHCN.
Healthy Tomorrows Project	The American Academy of Pediatrics (AAP) provided funding to Bradley Children's Hospital for the purpose of assuring a "medical home" for infants & children (including CSHCN) in foster care throughout the state. The DFH helped the Hospital develop the needs assessment and plan and participated on the Advisory Committee for the Project.
Home Visiting Program	The DFH contracts with culturally competent community-based visiting nurse agencies (VNAs) to provide education, home visiting services and linkages to other community-based support services. The Program primarily serves low-income and racially/ethnically diverse pregnant women and families with young children, including CSHCN. The Home Visiting Program serves pregnant women, families with newborns at risk for developmental delay, lead poisoned children, and children identified to be in need of preventive health services (i.e. immunizations, lead screening, etc.)
KIDSNET	Housed in the DFH, KIDSNET is an integrated information management and tracking system for metabolic screening, newborn screening, lead screening, immunization, WIC, Early Intervention, home visiting, and other preventive programs. KIDSNET serves all infants & children (including CSHCN) born as of 1-1/97 throughout the state. KIDSNET is considered to be a national model.
Newborn Screening Program	The DFH's Newborn Screening Program provides universal newborn screening for developmental risks, including socio-economic risks, through a Level I screening process. Screening is conducted through the DFH's Home Visiting Program, utilizing data produced by KIDSNET. Newborns identified to be at risk are referred to the DFH's Early Intervention Program and other appropriate support services.
Parent-Consultant Program	Located in the DFH, the Parent-Consultant Program recruits, trains and supports "parents as partners" for outreach, policy development, and evaluation. The DFH's Parent-Consultants serve the DFH's entire targeted maternal & child health population, which primarily target low-income families living in racially/ethnically diverse communities and CSHCN. The DFH's Parent Consultant Program employs culturally diverse parents and is considered to be a national model.
"Parents As Partners" State Systems Development Initiative (SSDI)	The DFH's SSDI Initiative supports culturally appropriate community needs assessment and planning activities designed to increase families' access to maternal and child health programs, including RIte Care. The initiative primarily serves low-income pregnant women and families with young children (including CSHCN) living in racially/ethnically diverse urban communities. Parents play an important role in the needs assessment, planning and implementation of the DFH's SSDI Initiative.
Rhode Island Food Security Monitoring Project (RIFSMP)	Housed in the DFH, the RIFSMP monitors the prevalence of hunger and food insecurity among low-income families, of which significant proportions are members of various racial/ethnic minority groups.
Vasectomy Media Campaign	Administered by the DFH's Family Planning Program in collaboration with the DFH's Communications Unit, the culturally competent Vasectomy Media Campaign promotes the DFH's Vasectomy Program.
Vasectomy Program	The DFH's Family Planning Program contracts with 14 private physicians to provide vasectomies for low-income, uninsured, "working" adult men. A significant proportion of the men who receive vasectomies through the DFH's Vasectomy Program are Hispanic or Portuguese.
Women, Infants, & Children (WIC) Media Campaign	Administered by the DFH's WIC Program in collaboration with the DFH's Communications Unit, the WIC Media Campaign increases public awareness about WIC Program services. The Campaign primarily targets working, non-English-speaking families receiving primary health care services from private physicians. Significant proportions of families receiving WIC services are members of racial and/or ethnic minority groups.

Women, Infants, and Children (WIC) Program	Located in the DFH, the WIC Program provides nutritious supplemental foods and culturally appropriate nutrition education to low-income pregnant women and families with young children, including CSHCN. Significant proportions of families receiving WIC services are members of racial and/or ethnic minority groups. WIC Program activities have been integrated with many of the DFH's other activities, including immunizations, lead screening, Early Intervention, etc.)
Women's Health Screening & Referral Program (WHSRP)	The DFH contracts with 11 family planning clinics to provides culturally appropriate no cost pregnancy testing and comprehensive health risk assessment and referral services to women and adolescent girls throughout the state, including those living in racially/ethnically diverse urban communities. The WHSRP is also working to address identified gaps in the continuum of care for women in Rhode Island through the development and implementation of new community partnerships.

TABLE 2

Title V Funded Preventive and Primary Care Services/Programs for Children

Program	Description
Programs for Pre-School Age Children	
Childhood Lead Poisoning Prevention Media Campaign	Administered by the DFH's Lead Program in collaboration with the DFH's Communications Unit, the Childhood Lead Poisoning Media Campaign increases public awareness about childhood lead poisoning prevention. The Campaign primarily targets low-income families with young children living in racially/ethnically diverse urban communities.
Childhood Lead Screening Program	Housed in the DFH, the Childhood Lead Screening Program assures that all young children throughout the state are screened for lead poisoning in accordance with existing state guidelines. The DFH contracts with the St Joseph Hospital Lead Center to screen low-income uninsured families with young children throughout the state. The DFH utilizes KIDSNET to track and provide follow-up to children who are out-of-compliance with existing guidelines. Out of compliance children are referred to the DFH's Home Visiting Program for follow-up. The DFH's Lead Program is considered to be a national model.
Child Opportunity Zone (COZ)/Starting Points Initiatives	The DFH provides Title V funding to the Rhode Island Department of Education to support the 13 school-linked COZ sites located throughout the state. Most of the state's COZ sites are located in racially/ethnically diverse urban communities. In addition, the DFH, in collaboration with the Rhode Island Departments of Human Services (DHS) & Education, the United Way of Southeastern New England, and RI KIDS COUNT, funds 9 Starting Points COZ Family Centers to provide culturally competent, school-linked early childhood services to families with children ages birth to five living in racially/ethnically diverse urban communities. Rhode Island is one of 11 Starting Points sites in the nation funded by the Carnegie Corporation of New York.
Communications Unit	Housed in the DFH, the Communications Unit develops and implements culturally competent health communications campaigns to improve child and family health throughout the state. The Unit serves the DFH's entire targeted maternal & child health population, which primarily target low-income families with children living in racially/ethnically diverse communities and CSHCN.
Family Resource Counselor (FRC) Program	The DFH contracts with 13 community health centers and 3 hospital-based clinics to employ culturally diverse FRCs to conduct outreach and referral to families potentially eligible for Rite Care, WIC, and other community-based support services. The FRC Program primarily serves low-income families living in racially/ethnically diverse communities.
Farmers Market Nutrition Program (FMNP)	The DFH provides low-income families and children enrolled in WIC with access to nutritious fresh foods through the culturally competent FMNP. A significant proportion of the families that are served by WIC live in racially/ethnically diverse communities

KIDS NET	Located in the DFH, KIDSNET is an integrated information management and tracking system for metabolic screening, newborn screening, lead screening, immunization, WIC, Early Intervention, home visiting, and other preventive programs. KIDSNET serves all infants & children (including CSHCN) born as of 1-1-97 throughout the state. KIDSNET is considered to be a national model.
Healthy Child Care	Housed in the DFH, Healthy Child Care develops policies and programs designed to promote the health and safety of children in childcare (including adolescents) through culturally appropriate infrastructure building activities, training and technical assistance, and collaboration with other agencies. Healthy Child Care primarily targets low-income families with children living in racially/ethnically diverse urban communities and CSHCN.
Healthy Tomorrows Project	The American Academy of Pediatrics (AAP) provided funding to Bradley Children's Hospital for the purpose of assuring a "medical home" for infants & children (including CSHCN) in foster care throughout the state. The DFH helped the Hospital develop the needs assessment and plan and participated on the Project's Advisory Committee.
Home Visiting Program	The DFH contracts with culturally competent community-based visiting nurse agencies (VNAs) to provide education, home visiting services and linkages to other community-based support services. The Program primarily serves low-income and racially/ethnically diverse pregnant women and families with young children, including CSHCN. The Home Visiting Program serves pregnant women, families with newborns at risk for developmental delay, lead poisoned children, and children identified to be in need of preventive health services (i.e. immunizations, lead screening, etc.)
Immunization Media Campaign	Administered by the DFH's Immunization Program in conjunction with the DFH's Communications Unit, the Immunization Media Campaign promotes childhood immunizations. The Campaign primarily targets low-income families with young children living in racially/ethnically diverse urban communities.
Immunization Program	Housed in the DFH, the Immunization Program provides no cost immunizations and conducts culturally appropriate immunization education activities for children throughout the state. The Program primarily targets low-income children and adolescents living in racially/ethnically diverse urban communities. Rhode Island currently enjoys the highest childhood immunization rate in the nation (> 90%).
Lead Outreach & Education Services	Located in the DFH, the Lead Program conducts culturally competent childhood lead poisoning prevention outreach & education activities throughout the state. The Program primarily targets low-income families with young children living in racially/ethnically diverse urban communities. HEALTH's Lead Program is considered to be a national model.
Parent-Consultant Program	Located in the DFH, the Parent-Consultant Program recruits, trains and supports "parents as partners" for outreach, policy development, and evaluation. The DFH's Parent-Consultants serve the DFH's entire targeted maternal & child health population, which primarily target low-income families living in racially/ethnically diverse communities and CSHCN. The DFH's Parent Consultant Program employs culturally diverse parents and is considered to be a national model.
"Parents As Partners" State Systems Development Initiative (SSDI)	The DFH's SSDI Initiative supports community needs assessment and planning activities designed to increase families' access to maternal and child health programs, including RIte Care. The initiative primarily serves low-income pregnant women and families with young children (including CSHCN) living in racially/ethnically diverse urban communities. Parents play an important role in the needs assessment, planning and implementation of the DFH's SSDI Initiative.
Rhode Island Food Security Monitoring Project (RIFSMP)	Housed in the DFH, the RIFSMP monitors the prevalence of hunger and food insecurity among low-income families, of which significant proportions are members of various racial/ethnic minority groups.
Women, Infants, & Children (WIC) Program	Housed in the DFH, the WIC Program provides nutritious supplemental foods and nutrition education to low-income pregnant women and families with young children,

	including CSHCN. Significant proportions of families receiving WIC services are members of racial and/or ethnic minority groups. WIC Program activities have been integrated with many of the DFH's other activities, including immunizations, lead screening, Early Intervention, etc.).
Programs for School-Age Children (Including Adolescents)	
Adolescent Media Campaign	Administered by the DFH's Adolescent & Young Adult (AYA) Unit in collaboration with the DFH's Communications Unit, the culturally competent Adolescent Media Campaign promotes positive images of youth and empowers adults to build meaningful relationships with adolescents. The Campaign primarily targets families with adolescents and other adults involved with adolescents throughout the state.
Blackstone Valley Interagency Collaborative (BVIC)	Through its active membership on the BVIC, the DFH supported this community-driven effort to coordinate services for adolescents in the racially/ethnically diverse urban communities of Pawtucket and Central Falls.
Chlamydia Project	Title X Region I provides funding to the Rhode Island Department of Health's (HEALTH's) Office of Sexually Transmitted Diseases (STDS) to reduce the prevalence of Chlamydia in women at risk, including adolescents. The Office of STDs funds the DFH's largest family planning clinic and one School-Based Health Center (SBHC) to provide culturally competent Chlamydia screening, education, and treatment services to women in 2 racially/ethnically diverse urban communities.
Communications Unit	Located in the DFH, the Communications Unit develops and implements culturally competent health communications campaigns to improve child and family health throughout the state. The Unit serves the DFH's entire targeted maternal & child health population, which primarily target low-income families with children living in racially/ethnically diverse communities and CSHCN.
Family Planning Program	The DFH contracts with 11 culturally competent family planning clinics to provide direct family planning services to individuals. The Program primarily serves low-income women and adolescents throughout the state. A significant proportion of the women and adolescents served through the Family Planning Program live in racially/ethnically diverse communities.
Fathers & Family Network	The DFH is a member of the community-based Fathers & Families Network, which is dedicated to developing and implementing activities that support fathers and fatherhood. The Network targets men with children of all ages.
Healthy Child Care	Located in the DFH, Healthy Child Care develops policies and programs designed to promote the health and safety of children in childcare (including adolescents) through culturally appropriate infrastructure building activities, training and technical assistance, and collaboration with other agencies. Healthy Child Care primarily targets low-income families with children living in racially/ethnically diverse urban communities and CSHCN.
Healthy School/Healthy Kids	HEALTH's Healthy Schools/Healthy Kids Initiative promotes a strong infrastructure for culturally competent school health programs through the implementation of infrastructure building activities, training and technical assistance, and collaboration with other agencies. The initiative primarily targets low-income school-age children living in racially/ethnically diverse urban communities. The DFH is a member of the Healthy Schools/Healthy Kids Coalition.
Healthy Tomorrows Project	The American Academy of Pediatrics (AAP) provided funding to Bradley Children's Hospital for the purpose of assuring a "medical home" for infants & children (including CSHCN) in foster care throughout the state. The DFH helped the Hospital develop the needs assessment and plan and participated on the Project's Advisory Committee.
Men 2 B Program	The DFH funds community-based agencies in 4 racially/ethnically diverse urban communities to train men to be effective role models for boys.
Northeast Injury Prevention Network	The DFH is a member of the Northeast Injury Prevention Network, which has been charged with developing a comprehensive statewide suicide prevention plan targeting at-risk adolescents in collaboration with other key stakeholders in Rhode Island.
Oral Health Coordinating Team	HEALTH's Oral Health Coordinating Team develops policies and programs to

	improve the oral health of low-income school-age children living in racially/ethnically diverse urban communities and CSHCN. The Team collaborates closely with a Team established by the Rhode Island Department of Human Services (DHS) to develop policies and programs to improve the oral health of children receiving Medicaid.
Parent-Consultant Program	Housed in the DFH, the Parent-Consultant Program recruits, trains and supports "parents as partners" for outreach, policy development, and evaluation. The DFH's Parent-Consultants serve the DFH's entire targeted maternal & child health population, which primarily target low-income families living in racially/ethnically diverse communities and CSHCN. The DFH's Parent Consultant Program, which employs culturally diverse parents and is considered to be a national model.
Rhode Island Children's Cabinet	The Children's Cabinet is made up of the Directors of the 5 state government agencies that serve children in Rhode Island (i.e. HEALTH; the Department of Human Services (DHS); the Department of Children, Youth & Families (DCYF); the Department of Education; and the Department of Mental Health & Retardation Hospitals (MHRH)). The Cabinet, which reports directly to the Governor, is charged with developing policies and promoting coordinated statewide programs to enhance the well being of children throughout Rhode Island. Presently, the Cabinet is working on implementing the recommendations made by the Governor's Juvenile Justice Task Force. The DFH works closely with HEALTH's Director on Cabinet activities.
Rhode Island Comprehensive Statewide Teen Pregnancy Prevention Partnership	HEALTH's DFH; the Department of Education, and the Department of Children, Youth & Families (DCYF) were charged with developing a comprehensive statewide teen pregnancy prevention plan by the state legislature.
School-Based Health Center (SBHC) Program	The DFH funds 7 culturally competent community-based SBHCs to provide comprehensive health and mental health services to adolescents. The SBHCs primarily serve low-income adolescents living in racially/ethnically diverse urban communities
Town Teen Network Program	The DFH funded 2 culturally competent community-based agencies to provide after-school programs for youth living in the racially/ethnically diverse urban communities of Providence and Pawtucket/Central Falls.
Women's' Health Screening & Referral Program (WHSRP)	The DFH contracts with 11 family planning clinics to provides culturally appropriate no cost pregnancy testing and comprehensive health risk assessment and referral services to women and adolescent girls throughout the state, including those living in racially/ethnically diverse urban communities. The WHSRP is also working to address identified gaps in the continuum of care for women in Rhode Island through the development and implementation of new community partnerships.
Youth Care Health Education Projects	Housed in the DFH the Community Youth Development Program funds four childcare providers to develop and implement strong culturally competent health education and youth development activities for youth in after-school care. The Program primarily serves youth living in racially/ethnically diverse urban communities.
Youth Input	The DFH contracts with the community-based, youth-led organization Youth In Action to provides culturally appropriate health education and information to low-income adolescents living in the racially/ethnically diverse urban community of Providence. This organization also brings the perspective of culturally diverse urban youth to program planning in the DFH.

TABLE 3

Title V Funded Services/Programs for Children with Special Health Care Needs	
Program	**Description**
Child Development Center (CDC)	The DFH contracts with the Rhode Island Hospital Child Development Center (CDC) to provide direct specialty and sub-specialty services and a "medical home" to medically complex CSHCN. The CDC serves CSHCN from birth through 21years of

	age.
Communications Unit	Housed in the DFH, the Communications Unit develops and implements culturally appropriate health communications campaigns to improve child and family health throughout the state. The Unit serves the DFH's entire targeted maternal & child health population, which primarily target low-income families with children living in racially/ethnically diverse communities and CSHCN.
CSHCN Program	Located in the DFH, the CSHCN Program develops and promotes family-centered community-based systems of care for CSHCN throughout the state through infrastructure building activities, training & technical assistance, and collaboration with other agencies.
Disabilities & Health Program	Housed in the DFH, the Disabilities & Health Program promotes access to care for individuals with disabilities through the implementation of population-based activities. The Program serves adults and CSHCN throughout the state.
Early Intervention (EI) Program	Located in the DFH, the EI Program provides direct early intervention services and a "medical home" to CSHCN from birth to three years of age throughout the state.
Environmental Lead Inspection Program	The Rhode Island Department of Health's (HEALTH's) Division of Environmental Health provides comprehensive environmental lead inspections, utilizing private inspectors, in the homes of significantly lead poisoned children (Pb $\geq$ 20 ug/dl). The Program primarily serves low-income young children living in racially/ethnically diverse urban communities. Rhode Island was one of the first states in the nation to secure Medicaid reimbursement for comprehensive environmental inspections for lead poisoned children. The Program represents one part of HEALTH's childhood lead poisoning prevention infrastructure.
Genetics Program	Housed in the DFH, the Genetics Program develops policies and programs designed to increase individuals' access to genetics services. The Program is funded through a HRSA Genetics Grant and serves the state's entire population, including CSHCN.
Groden Center	The DFH contracts with the community-based Groden Center to provides intensive mental/behavioral health services and a "medical home" to eligible children throughout the state. The Groden Center primarily serves infants and toddlers.
Healthy Child Care	Located in the DFH, Healthy Child Care develops policies and programs designed to promote the health and safety of children in childcare (including adolescents) through culturally appropriate infrastructure building activities, training and technical assistance, and collaboration with other agencies. Healthy Child Care primarily targets low-income families with children living in racially/ethnically diverse urban communities and CSHCN.
Healthy Tomorrows Project	The American Academy of Pediatrics (AAP) provided funding to Bradley Children's Hospital for the purpose of assuring a "medical home" for infants & children (including CSHCN) in foster care throughout the state. The DFH helped the Hospital develop the needs assessment and plan and participated on the Project's Advisory Committee.
Home Visiting Program	The DFH contracts with culturally competent community-based visiting nurse agencies (Vans) to provide education home visiting services and linkages to other community-based support services. The Program primarily serves low-income and racially/ethnically diverse pregnant women and families with young children, including CSHCN. The Home Visiting Program serves pregnant women, families with newborns at risk for developmental delay, lead poisoned children, and children identified to be in need of preventive health services (i.e. immunizations, lead screening, etc.)
KIDSNET	Housed in the DFH, KIDSNET is an integrated information management and tracking system for metabolic screening, newborn screening, lead screening, immunization, WIC, Early Intervention, home visiting, and other preventive programs. KIDSNET serves all infants & children (including CSHCN) born as of 1-1/97 throughout the state. KIDSNET is considered to be a national model.
Lead Case Management Services	The DFH contracts with the St. Joseph Hospital Lead Center in Providence to provide comprehensive case management services and a "medical home" to significantly lead-

	poisoned children (Pb $\geq$ 20 ug/dl). The Lead Center primarily serves low-income families with young children living in racially/ethnically diverse urban communities. The DFH also provides education and technical assistance to the lead clinics located at Memorial Hospital in Pawtucket and Hasbro Children's Hospital in Providence on an ongoing basis. Also, the DFH's Home Visiting Program provides lead education to families of children with elevated lead levels ($\geq$ 15 ug/dl) on a statewide basis. HEALTH's Lead Program is considered to be a national model.
Metabolic Screening Program	Located in the DFH, the Metabolic Screening Program provides universal newborn screening for 8 metabolic conditions.
Newborn Screening Program	The DFH's Newborn Screening Program provides universal newborn screening for developmental risks, including socio-economic risks, through a Level I screening process. Screening is conducted through the DFH's Home Visiting Program, utilizing data produced by KIDSNET. Newborns identified to be at risk are referred to the DFH's Early Intervention Program and other appropriate support services.
Oral Health Coordinating Team	HEALTH's Oral Health Coordinating Team develops policies and programs to improve the oral health of low-income school-age children living in racially/ethnically diverse urban communities and CSHCN. The Team collaborates closely with a Team established by the Rhode Island Department of Human Services (DHS) to develop policies and programs to improve the oral health of children receiving Medicaid.
Parent-Consultant Program	Housed in the DFH, the Parent-Consultant Program recruits, trains and supports "parents as partners" for outreach, policy development, and evaluation. The DFH's Parent-Consultants serve the DFH's entire targeted maternal & child health population, which primarily target low-income families living in racially/ethnically diverse communities and CSHCN. The DFH's Parent Consultant Program, employs culturally diverse parents and is considered to be a national model.
"Parents As Partners" State Systems Development Initiative (SSDI)	The DFH's SSDI Initiative supports culturally appropriate community needs assessment and planning activities designed to increase families' access to maternal and child health programs, including RIte Care. The initiative primarily serves low-income pregnant women and families with young children (including CSHCN) living in racially/ethnically diverse urban communities. Parents play an important role in the needs assessment, planning and implementation of the DFH's SSDI Initiative.
Rhode Island Hearing & Assessment Program (RIHAP)	The DFH contracts with the Rhode Island School for the Deaf to provide universal hearing screening and follow-up to newborns. Newborns lost to follow-up are referred to the DFH's Home Visiting Program. Rhode Island was the first state in the nation to provide universal newborn hearing screening.
School-Based Health Center (SBHC) Program	The DFH funds 7 culturally competent community-based SBHCs to provide comprehensive health and mental health services to adolescents. The SBHCs primarily serve low-income adolescents living in racially/ethnically diverse urban communities.
SSI Team	Housed in the DFH, the SSI Team assures that CSHCN throughout the state have access to SSI through the employment of infrastructure building activities, training and technical assistance, and collaboration with other agencies.
Traumatic Brain Injury (TBI)Program	Located in the DFH, the TBI Program conducts population-based traumatic brain injury surveillance activities on a statewide basis. The Program is funded through a grant from the U.S. Centers for Disease Control (CDC) and serves adults and children throughout the state. The TBI Program is expanding to include spinal cord injuries.
Women, Infants, and Children (WIC) Program	Housed in the DFH, the WIC Program provides nutritious supplemental foods and culturally appropriate nutrition education to low-income pregnant women and families with young children, including CSHCN. Significant proportions of families receiving WIC services are members of racial and/or ethnic minority groups. WIC Program activities have been integrated with many of the DFH's other activities, including immunizations, lead screening, Early Intervention, etc.)

1.5.1.3 Other Capacity

Key staff and parents working on Title V programs are listed in Table 4. Data capacity is addressed in Core Health Status Indicator #5 (See SD 5.4).

TABLE 4
State Title V Key Staff and Parents (Total = 11)

Senior Level Management				
Position Title/Category	**Program**	**FTEs**	**P, C, or V**	**Vacant #FTE's**
Medical Director	Office of the Medical Director	1.0	P	0
Assistant Medical Director	Office of the Medical Director	1.0	P	0
Chief of Staff	Office of the Medical Director	1.0	P	0
Key Administrator	Office of the Medical Director	1.0	P	0
Chief	MCH Policy & Communications Unit	1.0	P	0
Chief	Data & Evaluation Unit	1.0	P	0
Chief	Office of Children's Preventive Health Servcies	1.0	P	0
Chief	Office of Children With Special Health Care Needs (CSHCN)	1.0	P	0
Chief	Office of Women, Infants, & Children (WIC)	1.0	P	0
Chief	Adolescent & Young Adult (AYA) Health Unit	1.0	P	0
Parents				
Position Title/Category	**Program**	**FTEs**	**P, C, or V**	**Vacant #FTE's**
Program Manager	Parent-Consultant Program	1.0	C	0

P = Paid, C = Contract, V = Voluntary

Programs/Services for Pregnant Women, Mothers, and Infants

Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTE's
Medical Director	Office of the Medical Director	.33	P	0
Assistant Medical Director	Office of the Medical Director	.33	P	0
Chief of Staff	Office of the Medical Director	.33	P	0
Key Administrator	Office of the Medical Director	.33	P	0
Chief	MCH Policy & Communications Unit	.33	P	0
Chief	Office of Children's Preventive Health Services	.33	P	0
Chief	Office of Women, Infants & Children (WIC)	.50	P	0

Programs/ Services for Children

Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTE's
Medical Director	Office of the Medical Director	.34	P	0
Assistant Medical Director	Office of the Medical Director	.34	P	0
Chief of Staff	Office of the Medical Director	.34	P	0
Key Administrator	Office of the Medical Director	.34	P	0
Chief	MCH Policy & Communications Unit	.34	P	0
Chief	Office of Children's Preventive Health Services	.34	P	0
Chief	Office of Women, Infants & Children (WIC)	.50	P	0
Chief	Adolescent & Young Adult (AYA) Health Unit	1.0	P	0

P = Paid, C = Contract, V = Voluntary
Senior position, biography attached

Programs/Services for Children with Special Health Care Needs

Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTE's
Medical Director	Office of the Medical Director	.33	P	0
Assistant Medical Director	Office of the Medical Director	.33	P	0
Chief of Staff	Office of the Medical Director	.33	P	0
Key Administrator	Office of the Medical Director	.33	P	0
Chief	MCH Policy & Communications Unit	.33	P	0
Chief	Office of Children's Preventive Health Services	.33	P	0
Chief	Office of Children with Special Health Care Needs (CSHCN)	1.0	P	0

Planning, Evaluation and Data Analysis

Program	Position Title * = Senior Position, Biography Attached	FTEs	P, C, or V	Vacant #FTE's
Chief	Data & Evaluation Unit	1.0	P	0

P = Paid, C = Contract, V = Voluntary
* Senior position, biography attached

1.5.2 State Agency Coordination

See Table 5 for all key associations with the Title V program. See Supporting Documents Section on page 207 for other relationships (Medicaid Agreements).

TABLE 5
Key State Title V Relationships

Other State Human Service Agencies and Committees/Cabinets	Local and Federally Funded Agencies And Health Centers	Associations and Organizations	Tertiary Care Facilities and Universities
Governor's Council on Mental Health	ChildCare Support Network (CCSN)	Assistive Technology Advisory Council	Boston Children's Hospital
Governor's Juvenile Justice Task Force	Child Opportunity Zone (COZ) Family Centers	Blackstone Valley Interagency Collaborative	Brown University
Oral Health Coordinating Team	CHILDSPAN	Carnegie Corporation of New York	Butler Hospital
Permanent Legislative Commission on Brain Injury	Early Intervention Program Network	Child Opportunity Zone (COZ) Family Centers	Groden Center
Permanent Legislative Commission on Child Care	Family Planning Program Network	Chlamydia Project Regional Advisory Board	Hasbro Children's Hospital
Rhode Island Assembly on School-Based Health Centers (SBHCS)	Farmers Markets	CVS Pharmacy	Johnson & Wales University
Rhode Island Children's Cabinet	Fathers & Family Network	Easter Seals Foundation	Memorial Hospital
Rhode Island Comprehensive Statewide Teen Pregnancy Prevention Partnership	Home Visiting Program Network	Family Planning Advisory Council	Rhode Island College
Rhode Island Danforth Policymakers Team	Men 2 B Program Network	Family Voices Rhode Island	Rhode Island Hospital
Rhode Island Department of Children, Youth & Families (DCYF)	Ocean State Coalition	Hallmark Greeting Cards	St. Joseph Hospital
Rhode Island Department of Corrections	Rhode Island Health Center Association (RIHCA) & Network	Head Start	University of Rhode Island
Rhode Island Department of Education	Rhode Island School for the Deaf	Healthy Childcare America Advisory Board	Women & Infants Hospital
Rhode Island Department of Human Services (DHS)	School-Based Health Center (SBHC) Network	Healthy Schools/Healthy Kids Coalition	
Rhode Island Department of Mental Health, Retardation, & Hospitals (MHRH)	Town Teen Network	Healthy Tomorrows Project Advisory Committee	
Rhode Island Early Childhood Technical Assistance Task Force	Youth In Action, Inc	HELP Coalition	
Rhode Island General Assembly	WIC Program Network	Immunization Action Coalition	
Rhode Island Hearing Assessment Program (RIHAP) Follow-Up Committee		John Snow Institute (JSI), Inc.	

Rhode Island Interagency Coordinating Council		**Little Moccasins Program**	
Rhode Island Transition Council		**Minority Health Advisory Committee**	
Right Start Implementation Committee		**Mayor's Task Force on Early Childhood (Providence)**	
RIte Care Consumer Advisory Committee		**Mental Health Association of Rhode Island (MHARI)**	
		Northeast Injury Prevention Network	
		Professional Provider Community	
		Providence Smiles Program	
		Regional Poison Control Program Advisory Committee	
		Rhode Island Breast-Feeding Coalition	
		Rhode Island Chapter of the American Academy of Pediatrics (AAP)	
		Rhode Island Chapter of Jaycees	
		Rhode Island Chapter of the March of Dimes	
		R.I. Chapter of Rotary Club International	
		Rhode Island Developmental Disabilities Council	
		Rhode Island Genetics Task Force	
		R.I.G.H.A. Foundation	
		Rhode Island Healthy Mothers, Healthy Babies Coalition	
		Rhode Island Immunization Plan Coalition	
		Rhode Island KIDS COUNT	
		Rhode Island Parent Information Network (RIPIN)	
		Rhode Island Public Health Foundation	
		Rhode Island Safe Kids Coalition	
		Robert Wood Johnson Foundation	

		Special Olympics Rhode Island	
		Southeast Asian Economic Development Corporation	
		United Way of Southeastern New England	
		U.S. Centers for Disease Control & Prevention	
		U.S. Office of Juvenile Justice & Delinquency Prevention (JJDP)	

II REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

Please refer to Forms 3, 4, & 5 in Supporting Documents Section 5.8.

See Figure 2 (Figure 2 in Guidance) on page 25.

2.2 Annual Number of Individuals Served

Please refer to Forms 7, 8, & 9 in Supporting Documents Section 5.8.

2.3 State Summary Profile

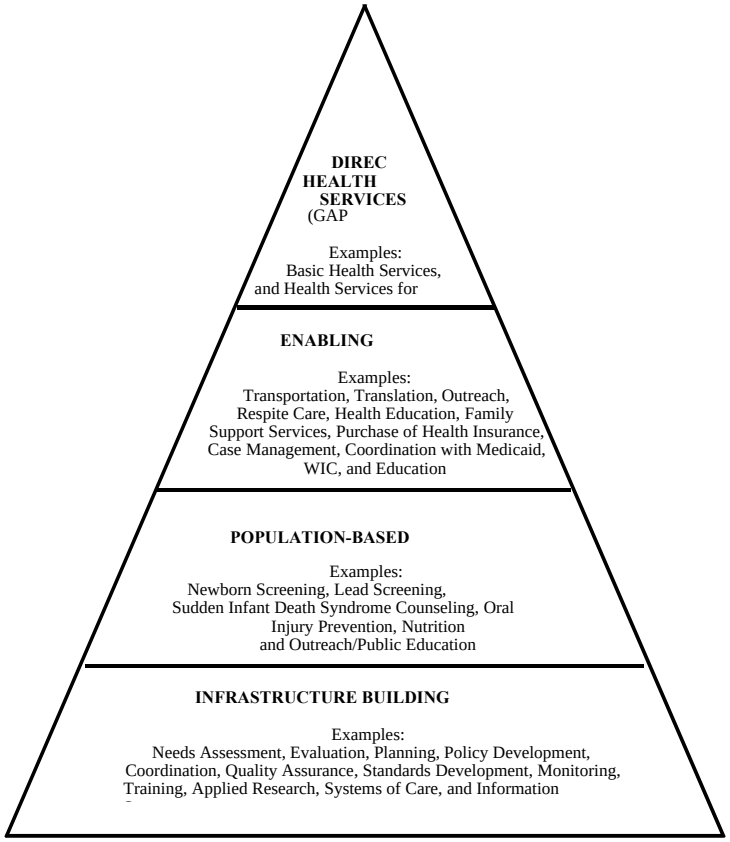
Please refer to Form 10 in supporting Documents Section 5.8.

2.4 Progress on Annual Performance Measures

See Table 6, which begins on page 26, for Title V Activities by Level of the Pyramid for MCH Populations. All indicators are documented on Form 11 in Supporting Documents Section 5.8.

Figure 2

CORE PUBLIC HEALTH SERVICES
DELIVERED BY MCH AGENCIES



MCHB/DSCH 10/20/97

TABLE 6
Title V Activities by Level of the Pyramid for MCH Populations

LEVEL OF PYRAMID	Activities for Pregnant Women, Mothers and Infants	Activities for Children	Activities for CSHCN
Infrastructure Building Services	Child Opportunity Zone (COZ)/Starting Points Initiatives Family Planning Program Genetics Services Healthy ChildCare Healthy Tomorrows Project Home Visiting Program KIDSNET Newborn Screening Program Parent Consultant Program "Parent As Partners" SSDI Initiative Rhode Island Food Security Monitoring Project WIC Program	Blackstone Valley Interagency Collaborative (BVIC) Childhood Lead Screening Program Child Opportunity Zone (COZ)/Starting Points Initiatives Chlamydia Project Community Youth Development Program Family Planning Program KIDSNET Healthy ChildCare Healthy Schools/Healthy Kids Healthy Tomorrows Project Home Visiting Program Immunization Program Northeast Injury Prevention Network Oral Health Coordinating Team Parent Consultant Program "Parents As Partners" SSDI Initiative Rhode Island Children's Cabinet Rhode Island Comprehensive Statewide Teen Pregnancy Prevention Partnership Rhode Island Food Security Monitoring Project (RIFSMP) School-Based Health Center (SBHC) Program Town Teen Network Program WIC Program Women's Health Screening & Referral Program (WHSRP) Youth Care Health Education Projects	CSHCN Services Early Intervention (EI) Program Genetics Services Healthy Child Care Healthy Tomorrows Project Home Visiting Program KIDSNET Metabolic Screening Program Newborn Screening Program Oral Health Coordinating Team Parent Consultant Program "Parents As Partners" SSDI Initiative Rhode Island Hearing & Assessment Program (RIHAP) School-Based Health Center (SBHC) Program SSI Team WIC Program

Population Based Services	**Breast-Feeding Media Campaign** **Disabilities & Health Program** **Vasectomy Media Campaign** **WIC Media Campaign** **Women's Health Screening & Referral Program (WHSRP)**	**Adolescent Media Campaign** **Childhood Lead Poisoning Prevention Media Campaign** **Communications Unit** **Immunization Media Campaign** **Lead Outreach & Education Services**	**Communications Unit** **Disabilities & Health Program** **Traumatic Brain Injury (TBI) Program**

TABLE 26
Title V Activities by Level of the Pyramid for MCH Populations*

LEVEL OF PYRAMID	Activities for Pregnant Women, Mothers and Infants	Activities for Children	Activities for CSHCN
Enabling Services	Family Resource Counselor (FRC) Program Farmers Market Nutrition Program (FMNP)	Family Resource Counselor (FRC) Program Farmers Market Nutrition Program (FMNP) Fathers & Family Network Men 2 B Program Youth Input	
Direct Health Care Services	Vasectomy Program		Child Development Center (CDC)-Transitioning To An Infrastructure-Building Activity Environmental Lead Inspections Groden Center-Transitioning To An Infrastructure-Building Activity Lead Case Management Services

*Services are organized in the category in which they best fit. Although some programs provide direct services (i.e. Family Planning Program, Home Visiting Program, WIC Program, Childhood Lead Screening Program, Immunization Program, SBHC Program, WHSRP, & Early Intervention Program), The Division of Family Health (DFH) has been focused primarily on strengthening the existing infrastructures for these programs.

NPM #1 –The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Status of Annual Performance Indicator: **27.5**

Indicator has: **(X)** Improved **( )** Stayed the same **( )** Not Improved

Objective Met/Exceeded: **(X)** Yes **( )** No

Source of Data: Rhode Island Department of Human Services

Population(s) Served: ( ) Pregnant Women, Mothers and Infants **( )** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 7. Programs to be reviewed/revised are in Table 8. See page 157 for FY 2001 annual plan for this measure.

TABLE 7
Programs/Activities Contributing to Success of NPM #1
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **SSI Team:** The DFH supported the activities of the statewide SSI Team, which was created in 1994 following the Supreme Court decision, Zebly, to provide a safety net for children eligible for SSI & their families.	I	R.I. is a 1914 A state (all children with SSI receive Medicaid benefits which includes rehabilitative services). The DFH utilized this period to increase children's access to SSI. Specifically, it provided information about re-application to families who have been denied or terminated by SSI through the Rhode Island Parent Information Network (RIPIN), tracked children who have been terminated by SSI with the state Department of Human Services (DHS) to increase reapplication rates, provided families with CSHCN with basic information about SSI eligibility and benefits through DHS, hospital sites, and Early Intervention sites, worked with the Easter Seals Foundation to develop a plan to identify 18 year old CSHCNs who may be eligible for SSI as a family size of one, and disseminated a package of basic information about SSI to physicians and other health care providers throughout the state through direct mailings.
2. **CSHCN Program**: The DFH worked closely with a community-based advocacy group to advocate on behalf of CSHCN, including CSHCN on SSI in need of rehabilitative services.	P	The community-based group, Family Voices, is a national organization, with a chapter in Rhode Island, whose mission is to advocate for CSHCN, ages birth through 21, on the national and state levels. Advocating that CSHCN on SSI receive appropriate rehabilitative servcies represents an important component of the group's ongoing efforts. Family Voices leadership meets regularly with DFH CSHCN staff and has membership on the DFH's SSI Team.
3. **Genetics Program**: Through the creation of a Core Genetics Group, the DFH will be taking the lead role in Health's efforts to provide an infrastructure for HEALTH to meet the challenges of the rapid advancements in genetics.	I	The Core Genetics Group is working closely with the Rhode Island genetics Task Force to develop strategies to increase public awareness about genetics and increase CSHCN's access to genetics services in 2001. The DFH anticipates that increasing access to genetics services will result in increased case identification.
4. **Early Intervention (EI) Program**: The EI Program served children, ages birth to 3, including those receiving SSI needing rehabilitative services.	I	The EI Program is mandated to provided comprehensive rehabilitation and education services to enrolled children. EI Program Parent-Consultants assist families with service planning and implementation. Although the DFH provides direct EI services, its recent efforts have primarily focused on strengthening the state's EI infrastructure and increasing existing service capacity. The DFH utilized this period to begin a process to revise and update its regional and statewide EI data

		systems to more effectively track and monitor the delivery of services.
5. **Disabilities & Health Program**: In collaboration with the state Department of Human Services (DHS), the DFH began a statewide survey designed to assess the effectiveness of services for CSHCN, including those receiving SSI.	I	The survey will assess access and quality of primary and specialty services for CSHCN receiving Medicaid and/or SSI or in foster care and therefore, not eligible for RIte Care. The survey will provide policymakers with important information as the state moves toward developing a more comprehensive, coordinated system of care for CSHCN, including those receiving SSI. Presently, CSHCN on SSI are carved out of the state's Medicaid managed care program, RIte Care.
6. **Child Development Center (CDC)**: The DFH supported the hospital-based CDC to provide specialty and subspecialty services to medically complex CSHCN, ages birth through 21.	D	Children with birth defects are evaluated and followed by the CDC, which is a part of Rhode Island Hospital. CDC clinics are available for most birth defects. Rare conditions are referred to Boston specialists. Most of the children receiving services through the CDC are receiving SSI. CDC staff link CSHCN receiving SSI with rehabilitative services.
7. **Parent-Consultant Program:** The DFH supports parent-consultants to assist with CSHCN program development and implementation.	E	DFH parent-consultants are members of the DFH's SSI Team and Core Genetics Group and are involved with addressing the rehabilitative needs of CSHCN receiving SSI through the DFH's EI Program, Disabilities and Health, CSHCN Program, and the CDC.
8. **Traumatic Brain Injury (TBI) Program:** The DFH supported a statewide TBI surveillance system based on hospital discharge data.	I	By state law, hospitals are mandated to report all head injury discharges to the DFH, for the purpose of helping adults and children with TBI secure access to appropriate services, including SSI and rehabilitative services. A 1997 state legislative mandate expanded to the DFH's TBI surveillance activities to include spinal cord injuries.

TABLE 8
Programs/Activities Needing Review/Revision for NPM #1
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
3. **Genetics Program (*)**: Created in 1998, the DFH's Genetics Program is a new initiative.	I	The DFH's plans are outlined in the DFH's 2-year HRSA infrastructure grant on genetics, which was granted during this time frame by the Maternal & Child Health (MCH) Bureau.
6. **Child Development Center (CDC):** Although the CDC will continue to provide direct services to eligible children, the DFH will focus on strengthening the quality assurance component of its contract with the CDC in 2001.	I	As a result, the CDC will considered to be an infrastructure-building activity in the DFH's Title V plan for 2001.

* = programs/activities that are new within the past 2 years.

NPM #2 – The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Status of Annual Performance Indicator: 9

Indicator has: **( )** Improved **(X)** Stayed the same **( )** Not Improved

Objective Met/Exceeded: **(X)** Yes **( )** No

Source of Data: Office of CSHCN

Population(s) served: (X) Pregnant Women, Mothers and Infants **( )** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 9. Programs to be reviewed/revised are in Table 10. See page 158 for FY 2001 annual plan for this measure.

TABLE 9
Programs/Activities Contributing to Success of NPM #2
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Early Intervention (EI) Program: The** DFH supported 5 statewide community-based regional early intervention agencies to provide specialty and sub-specialty services, including care coordination, to CSHCN, ages birth to 3.	I	Care coordination for children enrolled in EI is entitlement. The DFH is working to develop new certification standards for EI providers and increase the existing service capacity to meet recent increases in enrollment, which has outstripped existing resources. A rise in births, recent technological advancements, improved inter-agency collaboration, and increased identification and awareness are believed to be responsible for the increase in demand for EI services.
2. **CSHCN Program**: The DFH advocated for specialty and subspecialty services, including care coordination, for CSHCN, on the state level.	I	R.I. has developed a single system of specialty and sub-specialty services for CSHCN, as a part of the state's larger medical care and special education infrastructure. Except for Early Intervention (IDEA), the DFH works through larger systems to assure capacity and responsiveness for CSHCN. The DFH successfully advocated for an increase in Medicaid reimbursement rates for specialty and sub-specialty services, including care coordination. However, commercial care coordination rates remain low or non-existent for this population.
3. **Child Development Center (CDC):** The DFH supported the CDC to provide specialty and sub-specialty services for medically complex CSHCN, ages birth through 21.	I	The CDC is experiencing an increase in its caseloads. Endocrine care coordination services are now being leveraged through Medicaid through the CDC.
4. **Groden Center**: The DFH supported the Groden Center to provide services, including care coordination to CSHCN with an identified mental health/behavioral health concern.	D	The Groden Center provides care coordination to CSHCN with an identified mental/behavioral health concern. The Groden Center primarily serves infants and toddlers.
5. **Rhode Island Hearing & Assessment Program (RIHAP):** The DFH provided education, training, intervention, and support to families with children who have been identified as being deaf or hard of hearing.	I	The DFH has an HRSA infrastructure grant to support its RIHAP activities. RIHAP assures that children who are deaf or hard of hearing receive care coordination services.
6. **Disabilities & Health Program**: The DFH supported a variety of population-based activities designed to promote the	P	The DFH provided on-going training for providers on a variety of disabilities & health topics, including assertive technologies; supported a statewide conference on disabilities and health; conducted a survey on access to services among individuals with communications impairments; and developed a Disabilities Data Book for community

health & wellness of individuals with disabilities, including CSHCN.		agencies and policy-makers.

TABLE 10
Programs/Activities Needing Review/Revision for NPM #2
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
4. **Groden Center**: Although the Groden Center will continue to provide direct services to eligible children, the DFH will focus on strengthening the existing quality assurance component of its existing contract with the Groden Center.	I	The DFH's contract with the Groden Center will be expanded to accommodate this need in 2001. As a result, the Groden Center will be considered to be an infrastructure-building activity in the DFH's Title v plan for 2001.

* = programs/activities that are new within the past 2 years.

NPM #3 – The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"

Status of Annual Performance Indicator: 47.7

Indicator has: **(X)** Improved **( )** Stayed the same **( )** Not Improved

Objective Met/Exceeded: **( )** Yes **(X)** No

Source of Data: Rhode Island KIDS COUNT, Child Development Center (CDC), Early Intervention Program

Population(s) served: (X) Pregnant Women, Mothers and Infants **( )** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 11.

Programs to be reviewed/revised are in Table 12. See page 159 for FY 2001 annual plan for this measure.

TABLE 11
Programs/Activities Contributing to Success of NPM #3
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Early Intervention (EI) Program**: All children participating in EI had a "medical home" (i.e. linkage with a physician).	I	EI Program service coordinators facilitate and assure a linkage to primary health care services for this population.
2. **CSHCN Program**: The DFH assured that all of its CSHCN grant applications included a "medical home" component.	I	The DFH's Genetics and the Metabolic Screening grants currently include "medical home" components for CSHCN.
3. **Child Development Center (CDC)**: All children who received services through the CDC had a "medical home"(i.e. linkage with a physician).	I	Because their care needs are often complex, many CSHCN rely on specialists rather than community-based primary care providers. Therefore, the CDC is the "medical home" identified by families for many CSHCN receiving services there.
4. **Home Visiting Program**: The DFH provided home visiting services and risk response for pregnant women and families with young	I	The health insurance status and name of each child's primary care provider is assessed as a part of each DFH home visit. Through this process, the DFH assures that each child receiving home visiting and risk response services is linked with a primary care or specialty care provider and other support services, as appropriate. During this

children, including CSHCN, throughout the state.		period, the program was integrated into KIDSNET, rather than linked to KIDSNET. About 40% of the families who received home visiting services in 1999 were members of racial/ethnic minority groups.
5. Healthy Tomorrows Project: The DFH worked closely with primary care providers in the state to integrate foster children, including CSHCN, into a "medical home" (linkage with a primary care provider).	I	There are about 1000 children in foster care in Rhode Island. This project represents a pilot partnership between the DFH and the Department of children, Youth, and Families (DCYF), the RI Chapter of the American Academy of Pediatrics (AAP), the Maternal & Child Health Bureau (MCHB), and the Rhode Island Public Health Foundation. Since they move frequently, many children in foster care (including CSHCN) receive fragmented primary care services. The pilot utilizes DFH home visitors to gather health information on each foster child, which is then provided to each child's assigned primary care provider.
6. **KIDSNET**: The DFH supported the KIDSNET initiative, which is a statewide preventive health care tracking system for all children, including CSHCN.	I	The DFH is working toward full enrollment of all pediatric providers into KIDSNET to assure that all children (including CSHCN) who do not have a medical home (i.e. linkage with a primary care provider) are identified and referred for appropriate home visiting and risk response services.
7. **Disabilities & Health Program**: As a part of a statewide Transition Council, the DFH conducted a survey designed to identify barriers that CSHCN who are moving from high school to adulthood experience in accessing services, including primary care services (i.e. "a medical home").	I	The Transition Council is a multi-departmental effort to create policies and maximize resources to improve outcomes for this population. The survey was conducted to collect data that can be used to increase this population's access to services, including primary care.
8. "**Parents As Partners" SSDI Initiative**: The DFH provided families with children, including those with CSHCN, with assistance in establishing a "medical home".	I	The DFH provided funding and technical assistance to SSDI sites in the racially/ethnically diverse urban communities of Central Falls and Woonsocket to, among other things, support outreach and enrollment of local 'hard-to-reach" families into RIte Care, Early Intervention, WIC, Home Visiting, lead poisoning prevention, and immunization services. Parent involvement represented an important component of the SSDI initiative. Specifically, culturally diverse local "peer parents" were trained to educate "hard-to-reach" families in their communities about MCH services eligibility and assist them with enrollment. DFH parent-consultants assisted "peer parents" to share this information with other families through neighborhood house parties and community presentations. About 250 families were reached through these efforts.
9. **Newborn Screening Program**: This initiative identifies developmental delay through a comprehensive (Level I) screening process and identifies each child's pediatrician at birth.	I	During this period, the Level I Newborn Screening Program for developmental risk was integrated into KIDSNET, rather than linked to KIDSNET. The pediatrician may not be the same at the time of the first home visit, so the home visitor assures that a pediatrician is identified and utilized. Culturally competent home visiting services are provided through the DFH's Home Visiting Program.
10. **Lead Case Management Services**: The DFH collaborated with other stakeholders to establish a new Lead Center to provide	I	In partnership with the Rhode Island Department of Human Services (DHS) and the community-based HELP Coalition, the DFH participated in the development of a Lead Center in the racially/ethnically diverse City of Providence. Significantly lead poisoned children in some areas of the state are referred to the Lead

comprehensive care to significantly lead poisoned children (Pb = ≥ 20 ug/dl) under age 6.		Center for comprehensive care, which includes parent education, assistance with environmental inspection, coordination of medical follow-up, and identification of funding for lead hazard reduction. Through this initiative, the DFH has assured a "medical home" for a significant number of significantly lead-poisoned children & their families living in the racially/ethnically diverse community of Providence. Minority children are disproportionately affected by lead poisoning in Rhode Island.
11. **Child Opportunity Zone (COZ)/Starting Points Initiatives:** The DFH supported school-linked Child Opportunity Zone (COZ) Family Centers to link families with CSHCN to Medicaid, SSI, and a "medical home".	I	The DFH supported the state's 13 school-linked Child Opportunity Zone (COZ) Family Centers with Title V funds for activities related to COZ infrastructure and operations. In addition, the DFH supported the development and implementation of culturally competent early childhood programs administered by 9 of the COZ Family Centers utilizing funding from the Carnegie Corporation (Starting Points). The majority of the state's COZs are located in racially/ethnically diverse "core" urban communities.
12. **School-Based Health Center (SBHC) Program:** The DFH supported 5 SBHCs in urban communities to provide comprehensive medical and mental/behavioral health services to adolescents.	I	The number of children at risk for poor health outcomes has increased as children have lost access to care because their parents do not have health insurance. Even with expansions in RIte Care, one in every four poor children in Rhode Island remains uninsured. Almost three-quarters of Rhode Island's uninsured children live in "working" families that are ineligible for RIte Care. SBHCs represent the "medical home" for many adolescents living in urban communities. All of R.I.'s SBHCs are located in racially/ethnically diverse urban communities.

TABLE 12
Programs/Activities Needing Review/Revision for NPM #3
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
9. "Parents As Partners" SSDI Initiative: The DFH's SSDI initiative ended in early 2000.	I	The DFH will utilize 2000 and 2001 to expand the "Parents As Partners" model to Providence. Providence is a racially/ethnically diverse "core" urban community.
10. Lead Case Management Services (*): Created in October of 1998, the Lead Center is a new initiative.	I	In order to accommodate the cultural diversity of its client population, the Lead Center employs culturally diverse staff.

* = programs/activities that are new within the past 2 years.

NPM #4 –Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).

Status of Annual Performance Indicator: 99.8

Indicator has: **( )** Improved **(X)** Stayed the same **( )** Not Improved

Objective Met/Exceeded: **( )** Yes **(X)** No

Source of Data: Estimated, Using Universal Newborn Screening Database

Population(s) served: (X) Pregnant Women, Mothers and Infants **( )** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 13.

Programs to be reviewed/revised are in Table 14. See page 162 for FY 2001 annual plan for this measure.

TABLE 13

Programs/Activities Contributing to Success of NPM #4
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Women's' Health Screening & Referral Program (WHSRP):** The DFH provided no cost pregnancy testing and comprehensive risk assessment and referral for women with a suspected pregnancy.	I	The WHSRP is administered by the DFH's family planning clinics. Women with positive and negative pregnancy test results were assessed for genetic risks, including metabolic conditions. Pregnant women were referred to RIte Care, early prenatal care and genetics counseling. The WHSRP determined that uninsured women with negative pregnancy test results have limited opportunities to address identified genetics risks. The DFH plans to address this and other gaps, in the system of care for women in 2001. About 40% of the women who were served by the DFH's family planning clinics in 1999 were members of racial/ethnic minority groups.
2. **Metabolic Screening Program**: All newborns were screened for metabolic conditions.	I	Newborns who were born in hospitals were screened at birth prior to discharge. The families of infants who were born at home were referred to the DFH's Home Visiting Program for follow-up.
3. **KIDSNET**: The DFH developed a plan to provide primary care physicians with immediate metabolic screening results (both positives and negatives) for their pediatric patients.	I	The DFH plans to implement this plan in 2001. The Metabolic Screening Program is in the process of being integrated into KIDSNET, rather than linked to KIDSNET.
4. Genetics Program: The DFH's Core Genetics Group worked with KIDS NET to develop a plan to assure linkages with appropriate risk response services for CSHCN, including those in need of metabolic screening Services.	I	The DFH plans to implement this initiative in 2001. All children with genetic conditions will have a child health profile in a data warehouse (KIDSNET). The system will eliminate duplicity, provide appropriate risk response services, and track children in need of metabolic screening and/or services for metabolic conditions, to school age. The system will also provide new surveillance opportunities for the DFH. Native Americans and African Americans in Rhode Island have higher rates of births with congenital anomalies than White & Asians.
5. **Home Visiting Program**: The DFH provided home visiting services to at risk families and families with children with identified metabolic conditions.	I	KIDSNET was utilized to refer at risk pregnant women and newborns for home visiting services. The home Visiting Program serves children throughout the state and utilizes culturally diverse staff in racially/ethnically diverse communities.
6. "**Parents As Partners" SSDI Initiative:** The DFH supported community assessment and strategic planning activities designed to increase utilization of MCH services, including follow-up an support for families with children with identified metabolic conditions.	I	These activities resulted in the development of innovative strategies to increase utilization of services, including home visiting services, among "hard-to-reach" families in the racially/ethnically diverse urban communities of Woonsocket and Central Falls. The DFH's home Visiting Program provided follow-up and support to families with children with identified metabolic conditions. The DFH also supported the implementation phase of the DFH's SSDI initiative, which included the training of culturally diverse parents and providers on MCH programs.

TABLE 14
Programs/Activities Needing Review/Revision for NPM #4
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments

4. **Genetics Program (*):** The DFH's Genetics Program is a new initiative less than 2 years old.	I	
6. "**Parents As Partners" SSDI Initiative**: The DFH's SSDI Initiative ended in early 2000.	I	The DFH will utilize 2001 to expand the "Parents As Partners" model to Providence.

* = programs/activities that are new within the past 2 years.

NPM #5 –Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B

Status of Annual Performance Indicator: 89.1

Indicator has: **(X)** Improved **( )** Stayed the same **( )** Not Improved

Objective Met/Exceeded: **(X)** Yes **( )** No

Source of Data: National Immunization Survey

Population(s) served: ( ) Pregnant Women, Mothers and Infants **(X)** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 15.

Programs to be reviewed/revised are in Table 16. See page 163 for FY 2001 annual plan for this measure.

TABLE 15
Programs/Activities Contributing to Success of NPM #5
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Immunization Program:** The DFH provided vaccine to all providers, free immunizations to uninsured children, and immunization education to providers and the public to assure that children through age two were immunized.	I	Rhode Island has the #1 rank for immunization compliance in the nation (>90%). However, vaccination rates vary by ethnicity. According a recent National Immunization Survey, White, Non-Hispanic Rhode Island children have higher immunization rates than Hispanic Rhode Island children do. The DFH supported two hospital-based clinics to provide free immunizations to uninsured children living in the racially/ethnically diverse "core" urban community of Providence, and both clinics serve large numbers of legal and illegal immigrant children. In addition, the DFH supported the annual "Big Shots For Little Tots" health fair in two inner-city Providence sites, in conjunction with the R.I. Chapter of Jaycees, the R.I. Chapter of Rotary Club International, and Providence Community Health Centers. This health fair provides free immunizations and education through bi-lingual health care workers in a festive atmosphere. Attendance at this event tops 3,000 individuals each year.
2. **KIDSNET**: KIDSNET tracked all immunizations for children born as of 1-1-97 and sent reports to primary care providers on-line regarding children's compliance with immunization protocols.	I	Auto-dial messages or mailed well child reminders were also sent to families at specified intervals. Children who are behind on their immunization were referred to the Home Visiting Program. The HomeVisiting Program serves families throughout the state and employs culturally diverse staff in racially/ethnically diverse communities.
3. **Newborn Screening Program**: The DFH sent Hallmark congratulations cards to all families with newborns,	I	The newborn screening program utilizes the KIDSNET database to conduct this ongoing activity. All children born as of 1/1/97 are included in the KIDSNET database.

which included information about the importance of timely immunizations.		
3. **Home Visiting Program**: The Home Visiting Program provided outreach to families with children who are behind on their immunizations.	I	Home Visits included an educational component to assure that families were informed about the importance of childhood immunizations. Home visitors also assured that children who are behind on their immunizations were brought up-to-date.
4. **Immunization Media Campaign**: The DFH conducted a statewide media campaign to increase awareness about the importance of immunization.	P	A comprehensive media campaign was developed in the last quarter of 1998. Products produced included a 30-second television spot, bus shelters, posters and collateral. All pieces were produced in English and Spanish. Posters were mailed to every hospital emergency department, public libraries, licensed child care centers, home child care providers, and pediatric health care providers throughout the state.
5. **Healthy Child Care**: The DFH provided information to families through the Child Care Support Network to promote childhood immunizations.	E	The DFH supported culturally and linguistically appropriate tote bags to lend to parents on a variety of topics, including immunizations through the Child Care Support Network (CCSN). About 150 childcare providers throughout the state were reached through this strategy during this period. The DFH also mailed information about the importance of childhood immunizations directly to about 3,000 child care providers throughout the state, provided immunization resource materials to the state's child care training agency for child care providers (CHILDSPAN), and provided training to child care providers on the immunization component. CHILDSPAN's quarterly newsletter included child care health & safety information in English & Spanish in each edition.
6. **WIC Program**: The WIC Program checked the immunization status of children at certification and re-certification	I	Over 18,000 children under age five were on WIC during this period. Children identified as being behind on their immunizations were referred to the Home Visiting Program. The DFH provided assessments of the 4 largest WIC sites to assure compliance with immunization protocols. All indices were met. A significant proportion of the families who are enrolled in WIC are members of racially/ethnic minority groups.
7. "**Parents As Partners" SSDI Initiative**: The DFH provided SSDI communities with training and information about childhood immunizations.	I	The DFH trained culturally diverse local "peer parents" and community leaders in Woonsocket and Central Falls about the facts and myths of vaccines and the recommended childhood schedule, as well as rules and regulations for pre-school and school entry. 46% of the "hard-to-reach" families who participated in a DFH SSDI activity reported that they used immunization services after they received education through the "peer parents". Woonsocket and Central Falls are racially/ethnically diverse "core" urban communities.
8. **Child Opportunity Zone (COZ)/Starting Points Initiatives:** DFH supported school-linked COZ Family Centers to educate families with young children about the importance of timely immunizations.	I	COZ Family Centers also assisted families in establishing a 'medical home" through culturally competent outreach and referral to RIte Care and other appropriate community-based services, including the DFH's Home Visiting Program.
9. **Parent-Consultant Program**: The DFH supported a paid parent-consultant in the Immunization Program.	E	A bi-lingual DFH parent-consultant and the DFH's bi-lingual outreach & education coordinator participated in numerous health fairs and educational seminars in racially/ethnically diverse communities, schools, churches, and health centers throughout the

		state.

TABLE 16
Programs/Activities Needing Review/Revision for NPM #5
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
7. **"Parents As Partners" SSDI Initiative**: The DFH's SSDI initiative ended in early 2000.	I	The DFH will utilize 2001 to expand the "Parents As Partners" model to Providence.

* = programs/activities that are new within the past 2 years.

NPM #6 – The birth rate (per 1,000) for teenagers aged 15 through 17 years.

Status of Annual Performance Indicator: 21.5

Indicator has: **(X)** Improved **( )** Stayed the same **( )** Not Improved

Objective Met/Exceeded: **(X)** Yes **( )** No

Source of Data: Maternal & Child Health Database

Population(s) served: ( ) Pregnant Women, Mothers and Infants **(X)** Children (Adolescents) **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 17.

Programs to be reviewed/revised are in Table 18. See page 164 for FY 2001 annual plan for this measure.

TABLE 17
Programs/Activities Contributing to Success of NPM #6
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. School-Based Health Center (SBHC) Program: The DFH supported 5 SBHCs in Providence, Pawtucket, Central Falls, and Woonsocket to provide comprehensive health and mental health services to adolescents.	I	The DFH currently supports 7 SBHCs (1 more in Pawtucket and 1 more in Woonsocket). The state's SBHCs are funded through a variety of sources and sustained funding remains an important SBHC issue. Currently, mechanisms are being developed to address SBHC funding issues, including a Rhode Island Assembly on SBHCs and the work of the state's Children's Cabinet. Teens in need of family planing services are referred to the DFH's family planning clinics. There is much variation in teen pregnancy rates among different racial/ethnic groups in Rhode Island. African Americans and Hispanics have rates that are more than three times than that of Whites. All of the DFH's SBHCs are located in racially/ethnically diverse "core" urban communities.
2. Family Planning Program: The DFH supported 11 family planning clinics located throughout the state to provide no cost and low cost confidential reproductive health services to adolescents.	I	The funding formula for distribution of Title X family planning funds was revised to award enhanced funding to those agencies serving greater numbers of no cost clients, including adolescents. Family planning clinics promote clear messages about abstinence from sexual intercourse and encourage parental involvement. Almost 40% of the approximately 2,000 teens who received services through the Family Planning Program in 1999 were minorities.
3. Women's Health Screening & Referral Program (WHSRP): The WHSRP was implemented in the DFH's 11 family planning clinics to provide no cost pregnancy testing and health	I	Pregnant teens identified through the WHSRP were referred to early prenatal care and to the Rhode Island Department of Human Services' (RIDHS's) adolescent self-sufficiency programs. Teens with negative pregnancy test results were provided with family planning services. Currently, the DFH is piloting a comprehensive follow-up initiative in Cranston and Coventry targeting teens with negative pregnancy test results. Teens receive an "abstinence-based" service model that includes

risk assessment and referral for women requesting a pregnancy test, including adolescents.		a caring adult, school support, community service projects, and recreation.
4. Men 2 B Program: The DFH funded projects in Pawtucket/Central Falls, Newport, Providence, and Woonsocket), which focused on training adult males to be effective role models to boys.	E	The program is funded with Title V abstinence education funds and promotes abstinence from sexual intercourse, violence, and substance use among school-age youth. The DFH's Men 2 B sites are located in racially/ethnical diverse "core" urban communities.
5. Town Teen Network (TTN) Program: The DFH piloted adolescent after-school programs in Providence and Pawtucket/Central Falls.	I	Projects were successful in moving activities to the school setting and in coordinating with school activities. Both projects were able to incorporate a comprehensive set of culturally competent activities for youth, including summer and holiday programs, risk assessment and referral, health education, homework help, parenting workshops, and recreational activities. The DFH's Town Teen Network sites were located in racially/ethnically diverse "core" urban communities.
6. Blackstone Valley Interagency Collaborative (BVIC): The DFH supported the BVIC's efforts to coordinate services for adolescents in Pawtucket and Central Falls.	I	The BVIC completed initial planning for an employment programming model for 9th through 12th graders and alternative education experiences and mentoring for out-of-school 16 to 20 year olds. Since then, both Pawtucket and Central Falls have received significant planning grants from the U.S. Office of Juvenile Justice and Delinquency Prevention (JJDP) to reduce juvenile delinquency and to promote positive youth development. Both Pawtucket and Central Falls are racially/ethnically diverse "core" urban communities.
7. **Fathers & Family Network:** The DFH participated in this newly formed community-based network designed to bring together all parties interested in supporting fathers and fatherhood.	E	The Network now has a growing broad membership and a parent agency that provides management and clerical support. The Men 2 B initiative is being integrated with the work of the FFN.
8. **Adolescent Media Campaign:** The DFH supported development of materials for a statewide public media campaign designed to project positive images of youth, promote youth development, empower adults to build meaningful relationships with teens, provide appropriate discipline and set boundaries for youth.	P	A comprehensive needs assessment (including a review of the adolescent marketing and media literature), a series of focus groups with parents in the various regions of the state, and the development of a campaign theme occurred in 1999. Campaign materials were completed, including two 30-second television spots, a 60-second radio spot, a bus shelter, posters and collateral. All materials were produced in English and Spanish. The campaign kick-off is planned for January 2001.
9. **Rhode Island Comprehensive Statewide Teen Pregnancy Prevention Partnership:** The DFH collaborated with the state Departments of Human Services (DHS); Education; and Children, Youth and Families (DCYF) to develop	I	The plan, which was published in June 1999, made 9 recommendations to the state legislature and the Children's Cabinet. The plan set numerical goals for calendar years 1998 through 2005 and identified potential funding streams for initiatives. The DFH focused its training and technical assistance efforts in the activities of the teen pregnancy prevention collaborative. Those efforts focused on the role of youth development initiatives in preventing teen pregnancy and other poor outcomes for youth. DFH staff advocated that the plan should reflect a clear message that abstinence from sexual intercourse is the healthiest

a statewide teen pregnancy prevention plan in response to a legislative mandate.		option for school-aged youth and that abstinence should be the expected standard of behavior for youth. Low-income and minority teens have the highest rates of teen pregnancy in Rhode Island.
10. **Healthy Schools/Healthy Kids**: The DFH worked with Department of Education partners on the Healthy Schools/Healthy Kids framework to build a strong statewide infrastructure for comprehensive school health programs.	I	DFH staff chaired the health services workgroup to advance SBHCs and the youth development approach in racially/ethnically diverse urban communities in R.I. The DFH's SBHC program manager sits on the Healthy Schools/Healthy Kids Steering Committee.
11. The Rhode Island Children's Cabinet: The DFH supported the Children's Cabinet efforts to make adolescents a priority focus of its work, and along with the state Policy-Makers Team, has conducted strategic planning retreats and assigned work groups to address the implementation of the Governor's Juvenile Justice Task Force Report.	I	The Children's Cabinet Youth Success Cluster is focusing its work on supporting the strategic planning efforts taking place in Providence, Woonsocket, Central Falls, Pawtucket, and Newport. It is also working to move the Starting Right after-school initiative forward in the context of a statewide vision for youth.
12. **Home Visiting Program**: Adolescents who received home visiting services received family planning and birth control information & education.	I	Pregnant teens were also referred to the Department of Human Services' (DHS's) adolescent self-sufficiency programs.
13. **Parent Consultant Program:** The DFH, engaged the services of two men in their early 20's as parent-consultants to the DFH's Adolescent and Young Adult Health Unit.	E	The parent-consultants brought the perspective of single parenting fathers and youth to program planning for the Unit. Both parent-consultants were teen fathers and are bi-cultural.

TABLE 18
Programs/Activities Needing Review/Revision for NPM #6
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
5. Town Teen Network: The Rhode Island Department of Human Services (RIDHS) has implemented the Starting Right Program, which expands the existing child care subsidy and includes middle school after school programs.	I	DFH staff participated on the Starting Right implementation committee to develop program standards. The DFH is currently piloting a health education component for Starting Right Programs, which includes after school programs for youth. The DFH's 4 pilots sites are located in Providence, Warren, and Newport. As a result of Starting Right support for after-school programs, the DFH did not include the Town Teen Network initiative in its Title V plan for 2001. There are, however, long-term funding issues that need to be addressed on a statewide basis.
6. Blackstone Valley Interagency Collaborative	I	The DFH is currently participating with other state agencies that are members of the Youth Success Cluster to provide oversight and

(BVIC): The DFH expects to conduct its work with these communities through the Youth Success Cluster, which is sub-group of the Children's Cabinet.		technical assistance to the two communities. Since this work will be accomplished through a different infrastructure, the BVIC initiative will not be included in the DFH's Title V plan for 2001.
8. **Adolescent Media Campaign (*):** The Campaign is a new initiative less than 2 years old.	P	
9. **Rhode Island Comprehensive Statewide Teen Pregnancy Prevention Partnership:** The recommendations included in the plan have been communicated to the state legislature and the Children's Cabinet and are in various stages of implementation.	I	Since the DFH has completed its charge, this initiative will not be included in the DFH's Title V plan for 2001. Recommendations included in the plan, however, are moving forward and the Partnership continues to work towards their implementation and support.

* = programs/activities that are new within the past 2 years.

NPM #7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Status of Annual Performance Indicator: 47.5

Indicator has: **( )** Improved **( ) Stayed** the same **(X)** Not Improved

Objective Met/Exceeded: **( )** Yes **(X)** No

Source of Data: Estimated, Using Providence Smiles Program Data

Population(s) served: ( ) Pregnant Women, Mothers and Infants **(X)** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 19.

Programs to be reviewed/revised are in Table 20. See page 166 for FY 2001 annual plan for this measure.

TABLE 19
Programs/Activities Contributing to Success of NPM #7
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Oral Health Coordinating Team**: The DFH is a part of HEALTH's Oral Health Coordinating Team, which is charged with developing recommendations to improve oral health of school-aged children, including CSHCN.	I	Several communities in Rhode Island have been designated health professional shortage areas (HPSAs) for dental services by the federal Bureau of Primary Care. These communities are urban areas where there are large concentrations of low-income and minority children. Also, Medicaid reimbursement for dental care in Rhode Island remains low. HEALTH's Oral Health Coordinating Team is focusing on low-income children. Recommendations included the expansion of school-based services, the provision of community-based oral health and education, and the development and implementation of school oral health policies. This initiative is designed to address some of the major

		infrastructure issues involved with the provision of dental services to low-income Rhode Islanders. The Department of Human Services (DHS) is also in the process of examining the existing dental service delivery system for Medicaid recipients, including children. HEALTH is collaborating closely with DHS on these projects.
2. **CSHCN Program**: The DFH funded a pilot program to provide dental services to CSHCN in the racially/ethnically diverse urban community of Woonsocket.	D	Fewer than half of all CSHCN in Rhode Island receives dental services. This pilot expanded CSHCN's access to dental care in an area designated to be a health professional shortage area (HPSA) for dental care.
3. **Home Visiting Program**: Young children who received home visits were assessed for "baby bottle tooth decay" and their parents were provided with information about the importance of routine dental care.	E	The Home Visiting Program serves families throughout the state and utilizes culturally diverse staff in racially/ethnically diverse communities.
4. **WIC Program**: The DFH provided culturally appropriate informational materials to health care providers about "baby bottle tooth decay" and the importance of routine dental care to give to families enrolled in WIC.	E	Families receiving WIC servcies receive on-going information about "baby bottle tooth decay" and the importance of routine dental care through local WIC sites.
5. **Healthy Child Care**: The DFH provided information about childhood oral health through the Child Care Support Network (CCSN).	E	The DFH supported culturally and linguistically appropriate tote bags to lend to parents on a variety of topics, including childhood oral health, though the Child Care Support Network (CCSN). About 150 childcare providers were reached through this strategy during this period. The DFH also mailed information about the importance of childhood immunizations directly to 3,000 child care providers throughout the state, provided oral health resource materials to the state's child care training agency for child care providers (CHILDSPAN), and provided training to child care providers on childhood oral health topics. CHILDSPAN's quarterly newsletter included child care health and safety information in English and Spanish in each edition.

TABLE 20
Programs/Activities Needing Review/Revision for NPM #7
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. Oral Health Coordinating Team (*): Health's Oral Health Coordinating Team is a new initiative less than two years old.	I	Both RIDHS and HEALTH are in the process of restructuring their existing oral health service infrastructures. Expanding access to dental sealants for third grade children will be included as a part of these discussions.
2. CSHCN Program: The DFH's pilot program to provide dental services to CSHCN in Woonsocket has ended.	D	The pilot fielded tested an approach for Medicaid. Results of the pilot were shared with Rhode Island Department of Human Services (RIDHS) staff and HEALTH's Oral Health Coordinating Team. As a consequence, this categorical activity (the Woonsocket pilot) will no longer be included in future MCH applications.

* = programs/activities that are new within the past 2 years.

NPM #8 – The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Status of Annual Performance Indicator: 1.6 *(Same number documented on Form 11)*

Indicator has: **( )** Improved **( )** Stayed the same **(X)** Not Improved

Objective Met/Exceeded: **( )** Yes **(X)** No

Source of Data: MCH Database

Population(s) served: ( ) Pregnant Women, Mothers and Infants **(X)** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 21.

Programs to be reviewed/revised are in Table 22. See page 167 for FY 2001 annual plan for this measure.

TABLE 21
Programs/Activities Contributing to Success of NPM #8
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Home Visiting Program**: All families receiving home visiting services were provided with information regarding the proper use of child care seats, air bag safety, and the safest location for children (the back seat).	E	Low-income families receiving prenatal home visiting services though the DFH's Home Visiting Program were linked with the Rhode Island Safe Kids Coalition which, among other things, provides free car seats and auto safety education. There are disparities in child death rates among different racial/ethnic groups in Rhode Island. The child death rate for African Americans is more than two times than the rate for Whites.
2. **Early Intervention (EI) Program**: The DFH provided training on car seat safety for CSHCN to staff at one EI site (Meeting Street Center).	I	The DFH Program collaborated closely with the Rhode Island Safe Kids Coalition and Meeting Street Center on this systems development initiative. Meeting Street Center EI staff provide training to other regional EI staff on an as needed basis. The Meeting Street Center initiative focuses on the special care seat needs of CSHCN.
3. **Healthy Child Care**: The DFH's provided information to the Child Care Support Network to promote the health and safety of children in child care settings.	I	The DFH supported culturally and linguistically appropriate tote bags, though the child Care support Network (CCSN), to lend to parents on a variety of topics, including the proper use of child car seats, air bag safety, and the backseat as being the safest location for children. The Network proved 150 childcare providers with information on this topic during this period. The DFH also supported training and resource materials to the child care community on these topics through the state's childcare training agency (CHILDSPAN). CHILDSPAN's quarterly newsletter included child care health and safety information in English and Spanish in each edition.
4. **Women's Health Screening & Referral Program (WHSRP):** The WHSRP screened pregnant and non-pregnant women for substance abuse risks and referred all at risk women for	I	Although declining, alcohol-related motor vehicle deaths remains a serious problem in Rhode Island and in the nation. Of the children who are killed in alcohol-related automobile crashes, many are passengers in vehicles with drivers who had been drinking. Unfortunately, low-income uninsured women's access to substance abuse treatment services

substance abuse assessment and treatment services, as appropriate.		is limited in Rhode Island. The DFH will utilize 2001 to address this gap in the existing continuum of care for women.

TABLE 22
Programs/Activities Needing Review/Revision for NPM #8
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
2. Early Intervention (EI) Program: The DFH's EI Program will collaborate with HEALTH's Injury Control Program to strengthen the state's existing car seat safety program for children, including CSHCN, in 2001.	I	

* = programs/activities that are new within the past 2 years.

NPM #9 – Percentage of mothers who breastfeed their infants at hospital discharge.

Status of Annual Performance Indicator: 56.7

Indicator has: **(X)** Improved **( )** Stayed the same **( )** Not Improved

Objective Met/Exceeded: **( )** Yes **(X)** No

Source of Data: Universal Newborn Screening Database

Population(s) served: (X) Pregnant Women, Mothers and Infants **( )** Children **( )** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 23.

Programs to be reviewed/revised are in Table 24. See page 168 for FY 2001 annual plan for this measure.

TABLE 23
Programs/Activities Contributing to Success of NPM #9
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **WIC Program**: The DFH supported several activities designed to increase the percentage of women enrolled in WIC who breast-feed their infants.	I	The DFH expanded the TLC hospital-based breast-feeding support program for WIC participants prior to discharge from 6 days a week to 7 days a week. It also expanded the Mother-to-Mother Peer Counseling Program to provide culturally competent breast-feeding and support to WIC participants by adding 4 more peer counselors for a total of 15. In 1999, 56.7% of women in the state breastfed their infants at discharge. Rates among WIC participants increased from 10.6% in 1998 to 11.6% in 1999. The WIC Program employed minority professional and support staff to provide culturally competent breast-feeding support servcies to families enrolled in WIC. Special WIC mini-grants were awarded to 7 local WIC agencies for the WIC Breastfeeding Clinic Environmental Project, which was designed to encourage more women to breastfeed by making the WIC clinic more "breastfeeding friendly". The WIC Program initiated infant feeding classes for expectant

		WIC participants to learn about the benefits of breastfeeding as a preferable alternative to formula feeding at 2 local WIC sites. The WIC Program also provided continuing education training to WIC nutritionists and breastfeeding peer counselors on current breastfeeding topics.
2. Home Visiting Program: Breast-feeding Support was provided to all nursing mothers who received home visiting services.	E	As appropriate, linkages were made with lactation consultants and other breast-feeding support services.
3. **Breast-Feeding Media Campaign**: The DFH developed a statewide strategic plan designed to promote breast-feeding.	P	Although the proportion of women who breast-feed at hospital discharge has improved, the DFH is committed to see even greater improvements in rates. After assessing the current breast-feeding service delivery system, the DFH decided to delay the campaign until it can strengthen the overall system of supports for breastfeeding. The DFH's first efforts will focus on health care settings and provider education, health care plan policies and practices, and workplace policies and practices. The DFH partnered with the Rhode Island Breastfeeding Coalition to develop this initiative. The campaign will primarily target families living in low-income, racially/ethnically diverse communities, where KIDS NET has determined that breast-feeding rates are lower than the statewide average.
4. **Communications Unit**: The DFH supported breast-feeding promotion activities during National Breast-Feeding Week.	P	The DFH sponsored a World Breastfeeding Week Celebration in Newport. The guest of honor was Michael Jordan's' mother, who is an outspoken advocate for breastfeeding and other family issues. Over 200 individuals attended the celebration. The DFH also assisted the Rhode Island Breast-Feeding Coalition revise and produce a breast-feeding resource directory for health care providers and conduct a statewide breast-feeding conference for health care providers and para-professionals.
5. **KIDSNET**: KIDSNET tracked the percentage of mothers who were breast-feeding and bottle-feeding their babies through Home Visiting Program data.	I	KIDSNET found that women are more likely to breast-feed if they are older, married, educated, have a medium to high socio-economic status, and have private health insurance. White and Hispanic women are more likely to breast-feed than African American and Asian women in Rhode Island are.

TABLE 24
Programs/Activities Needing Review/Revision for NPM #9
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
3. **Breast-Feeding Media Campaign (*)**: The Campaign is a new initiative less than 2 years old.	P	
4. **Communications Unit**: The DFH's Communications Unit will work with the Rhode Island Breast-Feeding coalition to implement the Breast-Feeding Media Campaign in 2001,	P	As a result, Communication Unit role will be incorporated as a part of the Breast-Feeding Media Campaign in the DFH's Title V plan for 2001.
5. **KIDSNET(*)**: KIDSNET's ability to track	I	

breast-feeding rates is new and took place for the first time in 1999.		

* = programs/activities that are new within the past 2 years.

NPM #10 – Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Status of Annual Performance Indicator: 99.7

Indicator has: **( )** Improved **(X)** Stayed the same **( )** Not Improved

Objective Met/Exceeded: **( )** Yes **(X)** No

Source of Data: Estimated, Using Universal Newborn Screening Database

Population(s) served: (X) Pregnant Women, Mothers and Infants **( )** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 25. Programs to be reviewed/revised are in Table 26. See page 169 for FY 2001 annual plan for this measure.

TABLE 25
Programs/Activities Contributing to Success of NPM #10
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Rhode Island Hearing & Assessment Program (RIHAP)**:The DFH assures that all newborns receive hearing screenings and, if needed, a referral for an assessment and diagnosis, prior to hospital discharge.	I	The RIHAP Follow-Up Committee reviews RIHAP, Early Intervention, and total birth cohort data to assure Rhode Island's high penetration rates. The DFH reviewed the existing Early Hearing Detection and Intervention protocol to determine if it was meeting the needs of families. In addition, it increased the number of sites conducting automated ABR screening by two. RIHAP reduced the rate of false positive referrals for confirmatory diagnosis from 7% to 2%.
2. KIDSNET: The DFH utilized KIDSNET to track Rhode Island Hearing & Assessment Program (RIHAP) data.	I	Hearing data is routinely downloaded to KIDSNET.
3. **Home Visiting Program**: The DFH provided follow-up servcies to infants who were identified as being deaf or heard of hearing through RIHAP.	I	Infants who failed a hearing screening prior to discharge-received follow-up and referral services through the DFH's Home Visiting Program, as appropriate. The Home Visiting Program also tracked infants who were lost to follow-up by RIHAP.
4. **Child Development Center (CDC)**: The DFH-funded CDC partnered with Woman & Infants Hospital on a research project devoted to finding the gene responsible for hearing impairments as well as assuring linkages with the specialty unit within the hospital.	I	The DFH funds the CDC personnel involved in the project. Also, the leverage of systems in the Neonatal Intensive Care Unit (NICU) and (Pediatric Intensive Care Unit (PICU) is essential. Children can become deaf or hard of hearing after birth and a developmental specialty physician under Title V has assured a safety net for these children.

TABLE 26
Programs/Activities Needing Review/Revision for NPM #10
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
NPM #10: There are no activities needing revision at this time.		

* = programs/activities that are new within the past 2 years.

NPM #11 – Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

Status of Annual Performance Indicator: 98

Indicator has: **(X)** Improved **( )** Stayed the same **( )** Not Improved

Objective Met/Exceeded: **(X)** Yes **( )** No

Source of Data: Form 7 Line 4

Population(s) served: (X) Pregnant Women, Mothers and Infants **( )** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 27. Programs to be reviewed/revised are in Table 28. See page 170 for FY 2001 annual plan for this measure.

TABLE 27
Programs/Activities Contributing to Success of NPM #11
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Early Intervention (EI) Program**: The DFH paid for primary and specialty care services for CSHCN, ages birth to 3, in EI that were uninsured and under-insured.	I	EI is an entitlement program in Rhode Island. The EI Program requires that CSHCN receive services in a "natural" setting. Medicaid reimburses for services provided in such settings. However many private health insurance plans do not cover services, such as home visiting.
2. **Home Visiting Program**: The DFH assisted families to assure that CSHCN who were eligible were enrolled in RIte Care.	E	As part of the Home Visiting Program's family assessment protocol, families without health insurance were identified and helped to enroll in RIte Care.
3. **CSHCN Program:** The DFH partnered with Family Voices to advocate for more coverage for CSHCN with private health insurance, including referral to Medicaid and SSI.	P	This collaborative is ongoing.
4. **Genetics Program**: The DFH's Genetics Team identified the need for preventive genetics counseling and preemptive surgery, which are not currently paid by insurers.	I	Recent advances in genetics will create an increased demand for services. The DFH will work closely with state policy-makers and consumer groups to inform groups on the potential impact and enabling the DFH to address funding needs.
5. **Traumatic Brain Injury (TBI) Program**: The DFH provided training to school personnel to assure that children with TBI are identified and linked to appropriate services, including RIte Care, Medicaid, SSI, and school services.	I	The DFH has a CDC population-based grant to create a surveillance system for children & adults with TBI. The DFH's TBI registry identifies all individuals discharged from hospitals with TBI. During the reporting period, the DFH looked at data to determine if infants and toddlers with TBI were identified and referred to appropriate services. Currently, the DFH is working closely with the Department of Human Services (DHS) on developing strategies to provide improved services to the TBI population.

TABLE 28
Programs/Activities Needing Review/Revision for NPM #11
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
4. **Genetics Program (*):** The DFH's Genetics Program is a new initiative less than 2 years old.	I	

* = programs/activities that are new within the past 2 years.

NPM #12 – Percent of children without health insurance.

Status of Annual Performance Indicator: 8.4
Indicator has: **(X)** Improved **( )** Stayed the same **( )** Not Improved
Objective Met/Exceeded: **( )** Yes **(X)** No

Source of Data: Health Interview Survey

Population(s) served: (X) Pregnant Women, Mothers and Infants **(X)** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 29. Programs to be reviewed/revised are in Table 30. See page 171 for FY 2001 annual plan for this measure.

TABLE 29
Programs/Activities Contributing to Success of NPM #12
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Family Resource Counselor (FRC) Program**: The DFH supported culturally diverse FRCs in the state's health centers and outpatient hospital clinics to identify and enroll eligible families into RIte Care, WIC, the Family Assistance Program (FIP), and the Food Stamp Program.	E	Given the expansion of RIte Care during this period, a significant portion of the DFH's energy was devoted to identifying and referring potentially eligible families to RIte Care. The DFH funded culturally diverse FRCs in 13 community health centers and 3 hospital clinics to assist families in enrolling in RIte Care, WIC, food stamps, and the state's Family Independence Program (FIP, formerly AFDC). The DFH provided training and technical assistance to all FRC sites during the reporting period. The DFH also initiated a discussion of Medicaid match funds for FRC servcies with the Department of Human Servcies (DHS). DHS included funding for FRC Program through the state's CHIP enrollment campaign. The DFH participated in the CHIP meetings to develop and implement a statewide outreach initiative to enroll all uninsured Rhode Island children eligible for RIte Care.
2. Communications Unit: The DFH utilized the Communications Unit to promote the MCH Hotline as the single source for information about services for families and other population-based awareness activities.	P	The DFH conducted a culturally competent public awareness campaign under the slogan, "Make Health Part of Your Family". The DFH developed promotional flyers and advertisements for various publications and directories. Communications Unit staff attended health fairs and community events in racially/ethnically diverse communities and distributed educational and promotional materials in several languages. The campaign was connected to the toll-free MCH Hotline and referred callers without health insurance to RIte Care, sent out information on RIte Care to callers, and advised families about the availability of community-based outreach workers (FRCs) if additional assistance was needed with enrollment. DFH Communications Unit staff also participated in state-level inter-agency outreach meetings to keep abreast of outreach activities and major policy changes concerning RIte Care. MCH Hotline staff received training on the new RIte Care mail-in application along with community-based outreach workers, including FRCs. The Unit also conducted a series of focus groups with users and non-users of

		services as part of a comprehensive planning process to understand why families use or do not use DFH services. Information was collected on how and where to promote the DFH's'programs. This comprehensive needs assessment will be used to drive the development of promotional materials for the DFH. The DFH's Hotline has bi-lingual capacity.
3. **Parent-Consultant Program**: The DFH's parent-consultants received training about RIte Care and assisted the DFH with RIte Care outreach activities.	E	Parent-consultants helped the DFH distribute RIte Care mail-in applications to MCH Hotline callers. The DFH's culturally diverse parent-consultants also provided RIte Care outreach assistance at numerous school and childcare sites and in conjunction with an adolescent immunization program with the community-based "Providence Smiles" dental program. DFH Parent Consultants served on the state's RIte Care Consumer Advisory Committee, providing insight to reaching potential eligible children.
4. **School-Based Health Center (SBHC) Program:** The DFH supported Rite Care enrollment activities in the state's 5 SBHCs.	E	SBHCs served as an important link to the state's Medicaid managed care program, RIte Care. DFH parent-consultants conducted creative outreach strategies in SBHCs that resulted in the enrollment of significant numbers of adolescents. All of the DFH's SBHCs are located in racially/ethnically diverse "core" urban communities.
5. **Family Planning Program**: The DFH supported RIte Care enrollment activities in the state's 11 family planning clinics.	E	Adolescents and adults were targeted, resulting in the enrollment of significant numbers of individuals, including adolescents. Medicaid law assures that teens have access to confidential reproductive health services. Therefore, the DFH expects that, over time, it will have less need to use its scarce Title X funds to support the confidential family planning needs of this population. About 40% of the 2,000 teens who were served through the family planning clinics in 1999 were minorities.
6. **Home Visiting Program**: All families receiving home visiting services were assessed and referred to RIte Care, as appropriate.	E	The DFH's Home Visiting Program referred about 350 families to RIte Care during this period.
7. **WIC Program**: The DFH supported outreach activities in WIC settings to identify, refer, and enroll eligible families into RIte Care.	E	Uninsured children on WIC were referred to the RIte Care Program. As of June 1999, 91.5% of all WIC participants were insured. During the reporting period, 594 children were referred to RIte Care.
8. **Healthy Child Care**: The DFH utilized childcare settings to outreach to families potentially eligible for RIte Care.	E	The DFH provided culturally competent training to child care providers to help them understand the RIte Care enrollment process and how to help families access services. The DFH also targeted the Child Care Support Network's "Parent Information Nights" and Child Opportunity Zone (COZ) Family Centers to distribute RIte Care information to parents.
9. **Immunization Program**: All children receiving immunizations at free clinics were screened and referred to RIte Care.	E	Over 2,000 children were screened at the two DFH-funded hospital based clinics in the racially and ethnically diverse community of Providence and referred to RIte Care. Over 400 of siblings of children receiving services were also referred. In addition, 60 children were screened at the annual "Big Shots For Little Tots" health fair in inner city Providence.
10. **Childhood Lead Screening Program**: The DFH referred potentially eligible children identified through the summer screening program to RIte Care.	E	In partnership with the state's childcare community, a mobile "Family Van" contracted by the DFH offered lead screening to children under age six enrolled in 46 childcare centers throughout the state, and referred all uninsured children to RIte Care. The "Family Van" employed bi-lingual staff.
11. **Early Intervention (EI)**	E	Regional EI Program Service Coordinators were trained about the

Program: The DFH's EI Program assured that potentially eligible CSHCN were identified and referred to RIte Care and SSI.		Rite Care and SSI eligibility and screened potentially eligible children on an ongoing basis throughout 1999.
12. **Child Opportunity Zone (COZ)/Starting Points Initiatives:** The DFH supported school-linked COZ Family Centers to screen and assist families enroll in RIte Care.	I	The majority of the state's COZs are located in racially/ethnically diverse urban communities.
13. **"Parents As Partners" SSDI Initiative**: This systems development initiative helped families with children, including CSHCN, access health insurance.	I	The DFH provided funding and technical assistance to SSDI sites to support outreach and enrollment of culturally diverse local "hard-to-reach" families in Central Falls and Woonsocket onto RIte Care, SSI, and Medicaid. Local peer parents were trained to educate "hard-to-reach" families in their communities about these services and help them with the enrollment process. Culturally diverse SSDI parent-consultants assisted other families enroll into Rite Care, SSI, and Medicaid.

TABLE 30
Programs/Activities Needing Review/Revision for NPM #12
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
10. **Childhood Lead Screening Program**: The DFH no longer has funding to conduct this initiative.	E	U.S. Centers for Disease Control & Prevention (CDC) funding for this initiative has ended. As a result, the DFH will not include this initiative in its Title V plan for 2001.
13. **"Parents As Partners" SSDI Initiative:** The DFH's SSDI Initiative ended in early 2000.	I	The DFH will utilize 2000 and 2001 to expand the "Parents As Partners" model to Providence.

* = programs/activities that are new within the past 2 years.

NPM #13 – Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Status of Annual Performance Indicator: 77.8
Indicator has: **(X)** Improved **( )** Stayed the same **( )** Not Improved
Objective Met/Exceeded: **( )** Yes **(X)** No

Source of Data: Rhode Island KIDS COUNT

Population(s) served: (X) Pregnant Women (<19), Mothers and Infants **(X)** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 31. Programs to be reviewed/revised are in Table 32. See page 172 for FY 2001 annual plan for this measure.

TABLE 31
Programs/Activities Contributing to Success of NPM #13
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Home Visiting Program**: The DFH worked to assure that children potentially eligible for Medicaid received home visiting services paid by Medicaid.	I	Current Medicaid reimbursement rates for home visiting services are low, and there is presently no reimbursement for prenatal home visiting services. During this period, the DFH participated in a statewide

		committee to review, evaluate, and plan for a comprehensive continuum of home visiting services for the state. Medicaid paid for 69% of home visits in 1999. The remainder was paid for by the DFH.
2. **School-Based Health Center Program (SBHC)**: The DFH worked to assure that adolescents potentially eligible for Medicaid received SBHC services paid by Medicaid.	I	Three SBHCs submitted claims to third party payers, including RIte Care/Medicaid in 1999. They actually collected 26% of the submitted claims. The DFH coordinated with the Department of Human Services to facilitate meetings between the RIte Care health plans and SBHC staff to address policy and procedural opportunities and barriers to the effective reimbursement for services.
3. **Family Planning Program:** The DFH worked to assure that adolescents potentially eligible for Medicaid had access to confidential family planning services paid by Medicaid.	I	RIte Care guarantees confidentiality protection for teens that receive reproductive health services. Despite the enrollment of significant numbers of adolescents in RIte Care, about 40% of the adolescents served by the DFH's family planning clinics are reported to be uninsured. The DFH suspects that some of these teens have RIte Care, but do not use it because of concerns about confidentiality. The DFH plans to address this issue in 2001.
4. **Early Intervention (EI) Program**: The DFH analyzed data to determine the extent to which eligible CSHCN were receiving a Medicaid service being paid for with non-Medicaid funds.	I	The DFH shared the results of its examination with the Rhode Island Department of Human Services (RIDHS) and has asked RIDHS to provide training for EI staff on the Medicaid and SSI application processes. The EI Program parent consultant advocated for services for special needs families and directly assisted families understand Medicaid eligibility requirements
5. **Child Development Center (CDC)**: The DFH analyzed data to determine the extent to which Medicaid eligible CSHCN were receiving a service and the CDC not able to secure reimbursement.	I	The DFH plans to develop a plan to address this issue by providing training and technical assistance to the CDC in 2000-2001.
6**. "Parents As Partners" SSDI Initiative**: The DFH supported community efforts to assure that children potentially eligible for Medicaid received services paid by Medicaid.	I	The purpose of the SSDI initiative was to develop strategies that would engage culturally diverse isolated families to participate in preventive health services. Specifically, the DFH supported community-based needs assessment and strategic planning in Central Falls and Woonsocket. The SSDI Initiative utilized local parents to educate "hard to reach" families about Rite Care and the DFH's maternal & child health programs.
7. **Family Resource Counselor (FRC) Program**: The DFH initiated a discussion of Medicaid match funding for FRC services.	I	The DFH continued ongoing collaboration with the state Department of Human Services (DHS) and the Rhode Island Health Center Association (RIHCA) around supporting the culturally competent FRC Program through training and technical assistance. In 1999, DHS included funding for FRCs through the state's RIte Care enrollment campaign.
8. **Parent-Consultant Program:** The DFH supported parent-consultants to help community agencies conduct needs assessments as a part of the DFH's SSDI initiative.	I	The DFH's SSDI needs assessments solicited input on barriers to services utilization and included focus groups, written surveys, telephone interviews with parents, and in-person meetings with local agency staff. The DFH's SSDI Initiative targeted "hard-to-reach" families in the racially/ethnically diverse "core" urban communities of Pawtucket & Central Falls.

TABLE 32
Programs/Activities Needing Review/Revision for NPM #13
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
12. **"Parents As Partners" SSDI Initiative:** The DFH's SSDI Initiative ended in early 2000.	I	The DFH will utilize 2000 and 2001 to expand the "Parents As Partners" model to Providence.

* = programs/activities that are new within the past 2 years.

NPM #14 – The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

Status of Annual Performance Indicator: 18
Indicator has: **( )** Improved **(X)** Stayed the same **( )** Not Improved
Objective Met/Exceeded: **(X)** Yes **( )** No

Source of Data: Office of CSHCN

Population(s) served: ( ) Pregnant Women, Mothers and Infants **( )** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 33. Programs to be reviewed/revised are in Table 34. See page 174 for FY 2001 annual plan for this measure.

TABLE 33
Programs/Activities Contributing to Success of NPM #14
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Parent Consultant Program:** The DFH funded culturally diverse parent-consultants to assure family participation in the state's EI Program and other activities related to CSHCN.	I	The DFH supported a paid parent-consultant to serve as the key liaison to other paid-parent consultants working in the DFH's regional EI programs. This parent-consultant provides on-going support to the regional parent-consultants by conducting monthly meetings, by producing and disseminating a monthly parent newsletter, and by participating in DFH EI Program meetings on an on-going basis. Other parent-consultants assisted with the development and implementation of the DFH's statewide childhood lead poisoning prevention media campaign and participated on the DFH's Genetics Core Team Planning Committee, the Genetics Task Force, and in the Disabilities & Health Program. Both groups are working on developing a strategic genetics plan for public health in Rhode Island. On-going in-service training for DFH's paid parent-consultants was provided through the DFH's Parent-Consultant Program.
2**. Early Intervention (EI) Program**: The DFH supported paid parent-consultants in the 5 regional EI programs	I	EI is mandated to assure that parents participate in the EI services planning process. The EI Program utilized paid parent-consultants to conduct outreach and education, translation and interpretation, program monitoring (parents are a part of EI's ongoing quality assurance activities), materials review, community advocacy, family surveys, and grant reviews and to provide parent-to-parent support, and the parent perspective during regional EI program annual site reviews. A model to assure more effective parent-to-parent support is in the process of being developed by the DFH.
3. **SSI Team:** Parents from the community-based Rhode Island Parent Information	I	Parent-consultants have proven to be valuable members of the DFH's statewide SSI Team.

Network (RIPIN) participated on the DFH's SSI Team.		
4. **CSHCN Program**: The DFH partnered with Family Voices to advocate on behalf of CSHCN on the state and national levels.	E	The Director of Family Voices provided testimony at the public hearing for the DFH's Title V plan for 2001.
5. **Healthy Child Care:** The DFH supported efforts to identify parent concerns around finding childcare for CSHCN.	E	The state's existing childcare subsidy program, Starting Right, includes CSHCN. The DFH worked with the Rhode Island Parent Information Network (RIPIN), Family Voices, the Child Care Support Network (CCSN), and the Healthy Childcare America Advisory Board to identify parent concerns related to the lack of child care for CSHCN in "natural settings".
6. **"Parents As Partners" SSDI Initiative:** The DFH utilized parents in program and policy activities related to the SSDI Initiative.	E	The DFH's SSDI Initiative included a component that addressed the needs of CSHCN. Information from community assessments in Central Falls and Woonsocket was shared with local SSDI sites. The information was used to improve outreach, provider education, and customer service in these racially/ethnically diverse "core" urban communities.
7. **Lead Outreach & Education Services:** The DFH supported a parent consultant to conduct statewide lead outreach & education activities.	E	A DFH bi-lingual parent consultant worked closely with the DFH's bi-lingual outreach & education coordinator and participated in presentations to parent groups and other groups in racially/ethnically diverse urban communities on an ongoing basis throughout 1999.

TABLE 34
Programs/Activities Needing Review/Revision for NPM #14
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Parent-Consultant Program**: The DFH is in the process of issuing a new RFP for the Parent Consultant Program.	I	The new contract is expected to be in place in the fall of this year. At that time, the DFH will be able to recruit new parent consultants to replace those who have left for other employment opportunities. Funding for parents in the DFH's Early Intervention (EI) Program, Parent Consultant Program, and SSDI Initiative will be consolidated under the new contract.
6. **"Parents AS Partners" SSDI Initiative**: The DFH's SSDI Initiative ended in early 2000.	I	The DFH will utilize 2001 to expand the "Parents AS Partners" model to Providence.

* = programs/activities that are new within the past 2 years.

NPM #15 – Percent of very low birth weight live births.

Status of Annual Performance Indicator: 1.5
Indicator has: **(X)** Improved **( )** Stayed the same **(X)** Not Improved
Objective Met/Exceeded: **( )** Yes **(X)** No

Source of Data: MCH Database

Population(s) served: (X) Pregnant Women, Mothers and Infants **( )** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 35. Programs to be reviewed/revised are in Table 36. See page 175 for FY 2001 annual plan for this measure.

TABLE 35
Programs/Activities Contributing to Success of NPM #15
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Home Visiting Program**: All families receiving a prenatal home visit are provided with culturally appropriate information about the importance of prenatal care and referrals to support services as appropriate (smoking cessation, substance abuse treatment, etc.)	I	The Home Visiting Program represents one of the DFH's key investments in reducing very low birthweight births (less than 1500 grams). Although Rhode Island's very low birthweight rate is low, there is much disparity in very low birthweight rates among different racial/ethnic groups in Rhode Island. African Americans, Asians, and Hispanics have higher rates that those found among Whites. Higher very low birthweight rates are also seen among families living in the state's "core" urban communities. There has be no change in the proportion of single births that are very low birthweight births. However, there has been a significant rise in the proportion of multiple births that are very low birthweight births. The DFH's Home Visiting Program provides support services to families with very low birthweight babies. About 40% of the families who were served through the Home Visiting Program in 1999 were members of racial/ethnic minority groups.
2. **Women's Health Screening & Referral Program (WHSRP):** The WHSRP provided no cost pregnancy testing and health risk assessment and referral to women seeking a pregnancy test through the DFH's family planning clinics.	I	The WHSRP represents one of the DFH's key investments in reducing very low birthweight births. The WHSRP promotes early pregnancy identification and prenatal care. In addition, it is currently working to address gaps in the continuum of care for non-pregnant women. Specifically, the WHSRP has determined that low-income uninsured women with negative pregnancy test results have difficulty accessing folic acid, nutrition education, smoking cessation programs, genetics services, and mental health and substance abuse services in Rhode Island. The DFH plans to address these gaps in 2001. In Rhode Island, minority women are more likely to be uninsured than White women.
3. **Family Resource Counselor (FRC) Program:** The DFH funded FRCs in 13 community health centers and 3 hospital clinics to assist in enrolling families onto Rite Care, WIC, food stamps, and FIP.	I	The DFH's culturally competent FRC Program represents one of the DFH's key investments in reducing very low birthweight births. The FRC Program assures that pregnant women are enrolled into Rite Care and have access to prenatal care and other support services early in pregnancy.
4. **Newborn Screening Program**: The DFH identified low birthweight newborns and referred them to the Home Visiting Program for appropriate follow-up services.	I	Very low and low birthweight (less than 2500 grams) were considered to be at risk and were referred to the Home Visiting Program.

5. **Family Planning Program**: The DFH's Family Planning Program provides low-income women and adolescents with access to confidential reproductive health services, including family planning services.	I	The DFH's Family Planning Program, which is funded through a combination of federal Title X and state "family life" funds, is dedicated to preventing unintended pregnancies. It is estimated that between one-third and one-half of all pregnancies in Rhode Island are unintended. The DFH's Family Planning Program remains significantly under-funded. The DFH's family planning clinics utilize culturally diverse staff to provide services to clients in racially/ethnically diverse communities. Almost 50% of the clients who were served through the family planning clinics in 1999 were minorities.
6. **Vasectomy Program**: The DFH partnered with the Rhode Department of Human Services (DHS), on a pilot project to provide no cost vasectomies to uninsured and under-insured adult men throughout the state.	D	It is estimated that about 14% of Rhode Island's adult male population are uninsured for health care. Minority men are more likely to be uninsured than white, non-Hispanic men. The Vasectomy Program was designed to expand this population's access to vasectomy services and prevent unintended pregnancies. To date, 28 men received vasectomies through this initiative. More than one-third of these men were either Hispanic or Portuguese. One of the physicians participating in the DFH's Vasectomy Program has Spanish-speaking capacity.
7. Vasectomy Media Campaign: The DFH conducted a media campaign designed to increase public awareness about the Vasectomy Program during this period.	P	A press release, posters, brochures radio spots, and mailings, utilizing the theme "Is a Vasectomy Right For You?", were developed and disseminated by the DFH's Communications Unit during this period. Consumer materials were developed in English and Spanish and DFH's two bi-cultural male parent-consultants participated in the development of the materials and collateral utilized.
8. **Child Development Center (CDC)**: The DFH supported CDC's plans to study low birthweight births in Rhode Island & their relationship to the needs of CSHCN during this period.	E	The CDC plans to release its preliminary findings in 2001.
9. **"Parents As Partners" SSDI Initiative**: This systems development initiative helped "hard-to-reach" families access WIC, RIte Care, Home Visiting, Newborn Screening, and Early Intervention services.	I	The DFH utilized parent-to-parent outreach and education strategies and provider training to increase the enrollment of culturally diverse local "hard-to-reach" families into WIC, RIte Care, Home Visiting, Newborn Screening, and Early Intervention in the racially/ethnically diverse communities of in Woonsocket and Central Falls. All of these services are investments designed to prevent low birthweight births.
10. **Chlamydia Project**: The DFH supported a pilot project designed to reduce the prevalence of Chlamydia in at-risk women, including adolescents.	I	Chlamydia is the number one reported sexually transmitted disease (STD) in Rhode Island, surpassing gonorrhea by 4:1. Chlamydia infection can cause serious health concerns to the future of a woman's reproductive health. In 1995, Title X Region I and the U.S. Centers for Disease Control (CDC) became partners in their efforts to reduce the prevalence of Chlamydia in populations at risk by establishing a special project in the six New England states. In R.I., the HEALTH's DFH, Office of STDs, Laboratories worked together to provide no cost Chlamydia screening, education, and treatment to low-income uninsured women (including adolescents) receiving services through the DFH's largest family planning clinic in the racially/ethnically diverse City of Providence. The positivity rate for the women who were screened through this project in 1999 was 7%.
11. **WIC Program**: The DFH supported pregnant women's	E	WIC serves low-income families. Providing supplemental foods and nutrition education for pregnant women helps assure healthy

access to WIC services.		pregnancy outcomes.

TABLE 36
Programs/Activities Needing Review/Revision for NPM #15
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
7. **Vasectomy Media Campaign**: The DFH will implement the campaign in 2000.	P	The DFH does not plan to run the campaign in 2001. Therefore, this activity will not be included in the DFH's Title V plan for 2001.
9. **"Parents As Partners" SSDI Initiative**: The DFH's SSDI Initiative ended in early 2000.	I	The DFH will utilize 2000 and 2001 to expand the "Parents As Partners" model to Providence.

* = programs/activities that are new within the past 2 years.

NPM #16 – The rate (per 100,000) of suicide deaths among youths 15-19.

Status of Annual Performance Indicator: 4.6
Indicator has: **(X)** Improved **( )** Stayed the same **( )** Not Improved
Objective Met/Exceeded: **( )** Yes **(X)** No

Source of Data: MCH Database

Population(s) served: ( ) Pregnant Women, Mothers and Infant **(X)** Children (Adolescents) **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 37. Programs to be reviewed/revised are in Table 38. See page 177 for FY 2001 annual plan for this measure.

TABLE 37
Programs/Activities Contributing to Success of NPM #16
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Adolescent Media Campaign**: The DFH's planned adolescent media campaign addresses the mental health needs of adolescents through collateral material.	P	The DFH has plans to implement the campaign, which was developed during this period, in January 2001. Parents and other adult caregivers with concerns about adolescent mental health issues will be able to call the MCH Hotline and receive information about where they can go for more information and support.
2. **Town Teen Network (TTN) Program: Adolescents** who participated in the DFH's TTN Programs received education about youth asset development and adolescent mental health issues.	I	Teens in need of mental health services were referred to appropriate professionals.
3. **Men 2 B Program:** Men who participated in this initiative receive training in youth asset development and learned when and where to refer teens who need additional help	I	Teens in need of mental health services were referred to appropriate professionals. The project agencies provided training to role models in when and where to refer youth for help.
4. **Home Visiting Program**: All teens receiving prenatal home visiting services received mental health assessment and referral services.	I	Teens in need of mental health services were referred to appropriate professionals.
5**. School-Based Health Center (SBHC) Program**: The DFH's 5 SBHCs provided mental health counseling and referral services to adolescents, in addition to primary health	I	SBHCs represent an important access point to the state's mental health service delivery system by assuring critical linkages in an in-school setting. Teens identified by SBHCs to be in need of mental health services were

care services.		referred for appropriate follow-up.
6. CSHCN Program: The DFH participated On the Governor's Council on Mental Health to advocate for the inclusion of Children's mental health issues in the state's mental health plan.	I	Increased community-based capacity to address children's mental health service needs is very much needed in Rhode Island. The DFH will continue to advocate for the inclusion of children's mental health issues in the state's mental health plan.
7. **Healthy Child Care:** The DFH conducted a needs assessment to plan activities and workshops for childcare providers throughout the state.	I	The needs assessment resulted in a plan to conduct a conference on the identification of mental health issues in childcare settings. In addition, the DFH has incorporated the need for staff trained in mental/behavioral health as a part of the Child Care Support Network's (CCSN's) efforts.

TABLE 38
Programs/Activities Needing Review/Revision for NPM #16
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. Adolescent Media Campaign (*): The Campaign is a new initiative less than 2 years old.	P	
2. Town Teen Network: This pilot ended in 2000, with the creation of the statewide Starting Right childcare initiative.	I	As a result, this initiative will not be included in the DFH's Title V plan for 2001.

* = programs/activities that are new within the past 2 years.

NPM #17 – Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

Status of Annual Performance Indicator: 92.9
Indicator has: **(X)** Improved **( )** Stayed the same **( )** Not Improved
Objective Met/Exceeded: **( )** Yes **(X)** No

Source of Data: MCH Database

Population(s) Served: (X) Pregnant Women, Mothers and Infants **( )** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 39. Programs to be reviewed/revised are in Table 40. See page 178 for FY 2001 annual plan for this measure.

TABLE 39
Programs/Activities Contributing to Success of NPM #17
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Women's Health Screening & Referral Program (WHSRP):** By providing no cost pregnancy testing and comprehensive risk assessment and referral, women at risk for delivering very low birthweight babies were identified and referred for appropriate prenatal care and other supports early in pregnancy.	I	The majority of Rhode Island's very low birthweight babies are delivered at Women & Infants Hospital, which has state-of-the art high risk facilities. The DFH has focused on developing the infrastructure necessary to identifying women who are at risk for delivering a low birthweight infant and assuring that they are linked to appropriate prenatal care services.
2. **Home Visiting Program**: All families who received prenatal home visits were assessed for low birthweight risks and referred to appropriate medical follow-up and other supports.	I	The Home Visiting Program is an important link to assuring that high-risk pregnant women are identified and referred for appropriate follow-up care early in pregnancy.

3. **Early Intervention Program**: Linkages were made with the pediatric and neonatal intensive care units at Women & Infants Hospital to assure early contact with EI services.	I	A pediatric development physician working as a consultant for the DFH at the CDC provides training to personnel at the NICUs and PICUs at Women & Infants Hospital. This initiative assures that infants who are delivered at high-risk facilities are linked to early intervention services prior to discharge.
4. **Child Development Center (CDC):** The CDC provided training for Women & Infants Hospital and Hasbro Children's Hospital staff to assure the coordination of services and a "medical home" for this population.	E	The DFH's physician consultant at CDC provides training to personnel at the NICUs and PICUs at Women & Infants Hospital. This initiative assures that infants with medically complex needs in high-risk facilities are linked to appropriate follow-up services in a timely manner.

TABLE 40
Programs/Activities Needing Review/Revision for NPM #17
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
NPM #17: There are no activities needing revision at this time.		

* = programs/activities that are new within the past 2 years.

NPM #18 – Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Status of Annual Performance Indicator: 91.1
Indicator has: **(X)** Improved **( )** Stayed the same **( )** Not Improved
Objective Met/Exceeded: **(X)** Yes **( )** No

Source of Data: MCH Database

Population(s) Served: (X) Pregnant Women, Mothers and Infants **( )** Children **(X)** CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 41. Programs to be reviewed/revised are in Table 42. See page 179 for FY 2001 annual plan for this measure.

TABLE 41
Programs/Activities Contributing to Success of NPM #18
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Women's Health Screening & Referral Program (WHSRP):** The DFH provided no cost pregnancy testing and health risk assessment and referral to women.	I	By providing no cost pregnancy testing and comprehensive health risk assessment and referral, the DFH was able to assure that pregnant women were identified and referred to prenatal care and other community support services early in pregnancy. The rates of early entry into prenatal care vary among different racial/ethnic groups in Rhode Island. African Americans, Asians, and Hispanics have lower rates of entry into prenatal care than do Whites. Almost 50% of the women served through The DFH's family planning clinics are minorities.
2. **"Parents As Partners" SSDI Initiative:** The DFH supported community needs assessment and strategic planning to increase utilization of preventive health services, including early prenatal	I	The DFH facilitated collaboration between the Home Visiting Program and the SSDI sites to develop community-based strategies to identify and facilitate entry of pregnant women into early prenatal care in Central Falls & Woonsocket, which have high rates of delayed entry into prenatal care.

care.		
3. **Family Resource Counselor (FRC) Program:** The DFH supported culturally diverse FRCs in the state's health centers and hospital outpatient clinics to identify and enroll eligible families into RIte Care.	E	The DFH's culturally diverse FRCs provided outreach to pregnant women to encourage early prenatal care and medical coverage.
4. **Home Visiting Program:** All families who received prenatal home visiting services received education about the importance of prenatal care.	E	As appropriate, women were referred to medical care and/or RIte Care and other support services, as appropriate.
5. **Child Opportunity Zone (COZ)/Starting Points Initiatives:** The DFH supported school-linked COZ Family Centers to link families to RIte Care and a "medical home".	I	COZs assisted families in establishing a "medical home" through culturally appropriate outreach and referral to RIte Care and other appropriate community-based services, including the DFH's Home Visiting Program.
6. **WIC Program**: The DFH assured that pregnant women receiving WIC services received early prenatal care.	E	As appropriate, women were referred to medical care and/or RIte Care and other support services, as appropriate.

TABLE 42
Programs/Activities Needing Review/Revision for NPM #18
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
2. **"Parents As Partners" SSDI Initiative:** The DFH's SSDI Initiative ended in early 2000.	I	The DFH plans to expand the "Parents As Partners" model to Providence in 2001 & 2001.
6. **WIC Program**: More pregnant women are choosing to receive prenatal care through private physicians participating in RIte Care.	E	Although the WIC Program is a major component of the state's community health center infrastructure, the DFH will expand its outreach initiatives to private prenatal providers participating in RIte Care.

* = programs/activities that are new within the past 2 years.

SPM #1 –The number and percentage of children ages >18 months in childcare who are up-to-date on their immunizations.

Status of Annual Performance Indicator: 88.5
Indicator:
(X) has improved ( ) has stayed the same ( ) has not improved
Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: Annual Immunization Assessment Report

State Priority Need Being Addressed: Assure the health, safety, and optimal development of children in childcare settings.

Population(s) served: ( ) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 43. Programs to be reviewed or revised are in Table 44. See page 180 for FY 2001 annual plan for this measure.

TABLE 43
Programs/Activities Contributing to Success of SPM #1
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Child opportunity Zone (COZ)/Starting Points Initiatives**: The DFH supported Child Opportunity Zone (COZ) Family Centers to provide child care providers and families with information. COZs link local schools with after-school sessions for families with young children.	I	13 COZs were funded, including 9 with Starting Points early childhood projects. COZs distributed information to families on a variety of topics, including immunizations. Most of the state's COZs are located in racially/ethnically diverse "core" urban communities.
2. **Immunization Program**: The DFH conducted assessments at licensed child care centers, community health centers, WIC sites, kindergartens, and private physicians offices to monitor trends in the age-appropriate immunization status of children.	P	Children in childcare and Head start in Rhode Island have high rates of vaccination completion. The DFH provides these settings with feedback on historical and current rates as well as opportunities on how to improve their rates. The DFH provides ongoing informational services and distributes materials to ensure that childcare sites are aware of the current recommendations and regulations regarding childhood immunizations.
3. **Healthy Child Care**: The DFH conducted outreach to parents with children in child care settings to encourage up-to-date immunizations.	E	The DFH provided culturally appropriate resource materials to CHILDSPAN for child care providers, mailed information to all types of child care settings, provided training to child care providers, and met individual MCH Hotline requests for information, as appropriate.
4. **KIDSNET**: The DFH utilized KIDSNET to track the immunization status of children born as of 1-1/97.	I	Referrals were made to the Home Visiting Program, as appropriate.
5. **Home Visiting Program**: The DFH utilized the Home Visiting Program to assist children who were behind on their immunizations to bring them up-to-date.	I	All families who received home visiting services received culturally appropriate information & education about the importance of timely immunizations.
4. **Immunization Media Campaign**: The DFH conducted a statewide media campaign to increase awareness about the importance of immunization.	P	A comprehensive media campaign was developed in the last quarter of 1998. Products produced included a 30-second television spot, bus shelters, posters and collateral. All pieces were produced in English and Spanish. Posters were mailed to every hospital emergency department, public libraries, licensed child care centers, home child care providers, and pediatric health care providers throughout the state.
7. **Parent-Consultant Program**: A DFH bi-lingual parent-consultant conducted summer door-to-door surveys to determine if parents received appropriate immunization information from child care sites.	E	Families living in racially/ethnically diverse urban communities were presented with language appropriate materials about immunizations and given information about free clinics. Parents with barriers other than insurance were referred to the DFH's Home Visiting Program. An evaluation of the door-to-door initiative is being developed by the DFH's Data & Evaluation Unit.

TABLE 44
Programs/Activities Needing Review/Revision for SPM #1
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
6. **Parent-Consultant Program (*)**: The summer door-to-door immunization activity is a new initiative less than 2 years old.	E	

* = programs/activities that are new within the past 2 years.

SPM #2 – The percentage of students in schools with School-Based Health Centers (SBHCs) who are enrolled in SBHCs.

Status of Annual Performance Indicator: 33.5

Indicator: (X) has been revised ( ) has improved ( ) has stayed the same (X) has not improved

Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: SBHC Reports

State Priority Need Being Addressed: Improve the health, safety, and optimal development of adolescents.

Population(s) served: ( ) Pregnant Women, Mothers and Infants (X) Children (Adolescents) (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 45.

Programs to be reviewed or revised are in Table 46. See page 181 for FY 2001 annual plan for this measure.

TABLE 45
Programs/Activities Contributing to Success of SPM #2
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **School-Based Health Center (SBHC) Program**: The DFH conducted outreach to increase enrollment in the state's 5 existing SBHCs and made plans to increase the number of sites in 2000.	I	During the reporting period, the quality of SBHC services was enhanced through the development and implementation of SBHC guidelines, which included quality assurance standards. In addition, RIte Care protocols included the GAPS/Bright Futures standards that apply to SBHC services.
2. **Family Planning Program**: The DFH assured strong linkages between the state's SBHCs and the Family Planning Program, as appropriate.	I	The DFH provided SBHC staff in the community with training and technical assistance about the federal Title X Family Planning Program. SBHC students in need of birth control services were referred to Title X sites.
2. **Communications Unit**: The DFH provided training and technical assistance on special events planning and media relations to community SBHC staff.	E	The DFH assisted the Pawtucket SBHC in organizing and sponsoring a special event to announce the opening of its new SBHC during this period.
4. **Immunization Program**: The DFH provided information to SBHCs on the need for "catch-up" immunizations for teens.	E	The DFH developed and implemented a pilot project called "Vaccinate Before You Graduate", targeting high-school seniors at the racially/ethnically diverse Pawtucket SBHC to ensure that they had Hepatitis B, a second MMR, Td, Varicella, and Meningoccocal vaccines as appropriate. Culturally appropriate materials were utilized in this pilot project.

TABLE 46
Programs/Activities Needing Review/Revision for SPM #2
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
SPM #2: SPM # 2 has been revised and is now the percentage of students in schools with SBHCs who are enrolled in a SBHC.		SPM #2 used to be as follows: the number and percentage of students in school with SBHCs who receive SBHC services. The revised SPM #8 reflects the DFH's efforts to increase SBHC enrollment in schools with SBHCS.

* = programs/activities that are new within the past 2 years.

SPM #3 –The proportion of pregnant women who receive an alpha-fetoprotein (SFP) test.

Status of Annual Performance Indicator: 52.3
Indicator: (X) has been revised (X) has improved ( ) has stayed the same ( ) has not improved

Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: Women & Infants Hospital

State Priority Need Being Addressed: Expand access to genetics services during the preconception and prenatal periods.

Population(s) Served: (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 47. Programs to be reviewed or revised are in Table 48. See page 182 for FY 2001 annual plan for this measure.

TABLE 47
Programs/Activities Contributing to Success of SPM #3
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Child Development Center (CDC):** The DFH met with CDC staff to discuss the development and implementation of a patient satisfaction survey for parents with CSHCN being served at the CDC.	I	There are plans to implement the survey in 2001. The DFH also utilized the reporting period to plan for the development of a statewide infrastructure designed to prevent genetic conditions.
2. **Women's Health Screening & Referral Program (WHSRP)**: The WHSRP provides risk assessment and referral for women who had a pregnancy test who may be at risk of having a child with a condition that has genetic precursors.	I	At-risk women with positive pregnancy test results were referred to genetics counseling. Unfortunately, uninsured low-income non-pregnant women's access to genetics counseling services is limited. The DFH plans to address this gap in the continuum of care for women in 2001. All women participating in the WHSRP received education about the importance of taking folic acid prior to pregnancy.
3. **Genetics Program**: The DFH employed a parent-consultant to work on genetics issues in conjunction with the DFH's Core Genetics Group.	I	The Core Genetics Group plans to develop community-based partnerships and linkages to expand access to genetics services. The parent-consultant will be working on the creation of a Web Site on genetics targeting parents and professionals.
4. **WIC Program**: The DFH provided post-partum women in the WIC program with information about the importance of taking folic acid prior to pregnancy.	E	All local WIC agencies received culturally appropriate promotional materials about folic acid to distribute. Data from a recent Behavioral Risk Factor Survey (BRFS) of adults in Rhode Island indicates that African American women have lower rates of folic acid use than Whites and Hispanics.
5. **Family Planning Program**: The DFH provided folic acid to uninsured, low-income women receiving family planning services through the state's Title X family planning clinics.	E	The Rhode Island Chapter of the March of Dimes provided the DFH with multi-vitamin samples with folic acid and the DFH's Title X Program provided a one-year supply of multi-vitamins with folic acid for about 600 low-income, uninsured women who received services through the DFH's family planning clinics during this period.

TABLE 48
Programs/Activities Needing Review/Revision for SPM #3
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments

SPM #3: SPM #3 was changed to the proportion of pregnant women who receive an alpha-fetoprotein (AFP) test.		SPM #3 used to read as follows: the proportion of parents presenting at the Child Development Center (CDC) for conditions that have genetic precursors who report being offered timely genetics services. Although the DFH will continue to work to improve customer satisfaction at the CDC, the revised SPM #3 more accurately reflects the DFH's broader genetics efforts.
3. **Genetics Program (*):** The DFH's Genetics Program is a new initiative less than 2 years old.	I	

* = programs/activities that are new within the past 2 years.

SPM #4 –Percent of women who receive prenatal care in the first trimester by race/ethnicity and socio-economic status.

Status of Annual Performance Indicator: 83.3
Indicator: ( ) is new (X) has improved ( ) has stayed the same ( ) has not improved

Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: MCH Database

State Priority Need Being Addressed: Reduce and manage pregnancy risks.

Population(s) served: (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 49. Programs to be reviewed or revised are in Table 50. See page 183 for FY 2001 annual plan for this measure.

TABLE 49
Programs/Activities Contributing to Success of SPM #4
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Women's Health, Screening and Referral Program (WHSRP):** The DFH provided no cost pregnancy testing and referred pregnant women to early prenatal care.	I	The WHSRP is operated by the DFH's family planning clinics. Therefore, it is possible to link the WHSRP database with the Family Planning database to determine the percentage of women participating in the WHSRP who received prenatal care in the first trimester by race/ethnicity and socio-economic status.
2. **Newborn Screening Program**: The DFH's Newborn Screening Program tracked the percentage of women who received prenatal care in the first trimester by race/ethnicity and socio-economic status.	I	KIDSNET is utilized to refer pregnant women to prenatal care, as appropriate. The data was collected from birthing hospitals.
3. **Home Visiting Program:** Home Visitors Educated pregnant women about the importance of prenatal care during the first trimester and assured that they were linked to appropriate medical care.	I	The Home Visiting Program tracks the percentage of women who received prenatal care in the first trimester by race/ethnicity and socio-economic status.

TABLE 50
Programs/Activities Needing Review/Revision for SPM #4
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments

SPM #4: There are no activities needing revision at this time.		

* = programs/activities that are new within the past 2 years.

SPM #5 –Percent of children tested with lead levels greater than or equal to 10 ug/dl by race/ethnicity and socio-economic status.

Status of Annual Performance Indicator: 18.7
Indicator: ( ) is new ( ) has improved ( ) has stayed the same (X) has not improved

Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: Lead Screening Database

State Priority Need Being Addressed: Provide education, support , and environmental risk reduction to families.

Population(s) served: ( ) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 51. Programs to be reviewed or revised are in Table 52. See page 184 for FY 2001 annual plan for this measure.

TABLE 51
Programs/Activities Contributing to Success of SPM #5
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **KIDSNET**: The DFH utilized KIDSNET to identify children with no evidence of lead screening, identify barriers to timely screening, and to update addresses through the use of KIDSNET generated reports.	I	In Rhode Island, the proportion of children with lead poisoning has been decreasing. The DFH continued to use the KIDSNET database to generate monthly reports and identify children with no evidence of screening. In addition to an outreach letter sent directly to about 300-400 parents monthly, a pilot telephone interview was conducted to identify barriers to timely screening.
2. **Childhood Lead Screening Program**: The DFH screened children who had never been screened before through a summer screening program.	I	During the months of May through July 1999, a total of 999 children were offered lead screening in a total of 46 childcare centers in the state. 215 children were found to have no prior screening record in the DFH's database.
3. **Lead Case Management Services**: The DFH supported the creation of new Lead Center to provide significantly lead poisoned children ($\geq$ 20 ug/dl) with comprehensive care.	I	Significantly lead poisoned children in Rhode Island receive case management through one of two agencies – through the Lead Center or through the DFH's Home Visiting Program if the child resides outside of the Lead Center's catchment area. The Home Visiting Program provides lead education in the child's home. Children residing in the state's "core" urban communities have higher rates of lead poisoning than the statewide average. Asian, African American, and Hispanic children are disproportionately affected by childhood lead poisoning in Rhode Island. Both the Lead Center and the Home Visiting Program provide culturally competent services.
4. **Home Visiting Program**: The DFH provided children with moderately elevated lead levels with lead education as a preventive measure.	I	Starting March 1999, the DFH began to process referrals for all children with lead levels 15-19 ug/dl. Referrals are sent to the Home Visiting Program, which has agencies in various region of the state. Families living in racially/ethnically diverse communities received culturally competent services.

5. **Environmental Lead Inspections**: The DFH offered all significantly lead-poisoned children an environmental lead inspection.	I	As a part of the range of services provided to significantly lead poisoned children, the DFH continues to process referrals for environmental lead inspections. HEALTH's Office of Environmental Health contracts with private inspectors conduct inspections in a timely manner.
6. **Lead Outreach & Education Services:** The DFH conducted lead education & outreach activities on an ongoing basis.	P	The DFH conducted community culturally and linguistically appropriate presentations and seminars in collaboration with school departments, parent support organizations working with minority population and participated in health fairs and other community-based parent activities to disseminate incentives and lead prevention messages. It also conducted 2 "Train the Trainers" workshops for community-based organization staff working with minority groups and school personnel to build strong community-based infrastructure for lead education and outreach.
7. Healthy Child Care: The DFH reached out to family-based and center-based childcare sites to promote lead screening and lead safe practices.	E	The DFH provided support to the Child Care Support Network (CCSN), which uses culturally and linguistically appropriate lending tote bags on a variety of topics, including childhood lead poisoning prevention. Childcare providers were also routinely included in the DFH's mass mail outs of culturally appropriate educational materials, which included information about childhood lead poisoning prevention. Distribution activities included 3,000 child care providers.
8. **WIC Program**: The DFH assured that families of children with lead levels $\geq$10 ug/dl are referred to WIC for nutritional counseling and access to nutritious foods.	E	The Lead Center and the Home Visiting Program referred children with elevated lead levels to WIC, where their families received supplemental foods and culturally appropriate nutrition education. It is believed that a diet high in iron and low in fats can decrease an elevated lead level in a child.
9. **Early Intervention Program**: The DFH provided training to regional EI Program staff to identify lead poisoned children and refer them to appropriate follow-up services.	E	Regional EI Service Coordinators incorporate each child's lead-related needs as a part of the child's Individual Family Service Plan (IFSP).
10. **Immunization Program**: The DFH added questions about lead screening in all physician, school, and pre-school immunization assessment sites	E	As a result of school assessments, school nurse teachers requested revisions on health screening forms to include specific lead screening language.
11. **"Parents As Partners" SSDI Initiative**: The DFH's SSDI Initiative conducted outreach to culturally diverse "hard-to-reach" families in Central Falls and Woonsocket.	I	46% of the "hard-to-reach" families who participated in this initiative reported that they utilized lead screening services after they received education through culturally diverse local "peer parents".
12. **Child Opportunity Zone (COZ)/Starting Points Initiatives**: The DFH supported bilingual staff at two lead treatment sites.	E	The lead treatment centers are Fatima Health Center and Memorial Hospital, which are located in the racially/ethnically diverse communities of Pawtucket and Central Falls.
13. **Childhood Lead Poisoning Prevention Media Campaign**: The DFH conducted a statewide media campaign to increase public awareness about childhood lead poisoning prevention.	P	Products included a 30-second television spot, a 60-second radio spot, a king-size exterior bus card, posters, and collateral. All pieces, except the bus card, were produced in English and Spanish. In October of 1998, the first wave of the campaign was launched. Monthly targeted mailings of posters and educational materials were sent out to health care providers, childcare providers, community-based agencies, food pantries, religious organizations, libraries,

		etc. In April of 1999, the Governor proclaimed May Lead Poisoning Prevention Month. A special event was held to kick-off the month (second wave), which focused on efforts to make child care centers lead-safe for children. CVS pharmacy became a funding partner by supporting the printing of educational materials.

TABLE 52
Programs/Activities Needing Review/Revision for SPM #5
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
2. **Childhood Lead Screening Program**: The DFH's funding from the U.S. Centers for Disease Control (CDC) for the summer screening program has ended.	I	Although the DFH will not include the summer screening program in its Title V plan for 2001, the DFH will continue to assure that uninsured children can receive no cost screening through the Lead Center.
11. **"Parents As Partners" SSDI Initiative**: The DFH's SSDI Initiative ended in early 2000.	I	The DFH will utilize 2000 and 20001 to expand the "Parents As Partners" model to Providence.
12. **Childhood Lead Poisoning Prevention Media Campaign:** The Media Campaign ended in 2000.	P	Although this initiative will not be included in the DFH's future MCH applications, the DFH will continue to conduct population-based lead outreach and education in other ways.

* = programs/activities that are new within the past 2 years.

SPM #6 – Percent of 9th graders who are expected to graduate from high school.

Status of Annual Performance Indicator: 82.9
Indicator: ( ) is new (X) has improved ( ) has stayed the same ( ) has not improved

Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: Rhode Island Department of Education

State Priority Need Being Addressed: Strengthen partnerships between school, neighborhood, and home.

Population(s) served: ( ) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table53. Programs to be reviewed or revised are in Table 54. See page 186 for FY 2001 annual plan for this measure.

TABLE 53
Programs/Activities Contributing to Success of SPM #6
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. Town Teen Network: The DFH provided after school programs to youth in Providence and Central Falls/Pawtucket.	I	There is a shortage of after-school programs for children aged 11-14. One in five Rhode Island middle-school children are home without adult supervision for more than 3 hours on at least three days a week. Young people left on their own are at significantly higher risk for becoming involved in risk behaviors. The state's 5 "core" urban communities have the highest high school drop-out rates.
2. School-Based Health Center (SBHC) Program: The DFH's SBHCs provided teens with access to a comprehensive array of	I	The DFH's SBHCs increase the ability of teens to address their health needs in an in-school setting. Graduating from high school represents an important lifetime health indicator.

preventive health and mental health services.		All of the DFH's SBHCs are located in racially/ethnically diverse "core" urban communities.
3. Family Planning Program: The DFH supported confidential family planning services to teens to prevent pregnancies, which can interfere with educational goals.	I	The Family Planning Program provided confidential culturally competent family planning services to about 2,000 teens during this period. About 40% of the teens who were served through the family planning clinics in 1999 were minorities.
4. Men 2 B Program: The Men 2 B initiative utilized a youth development approach to build community capacity for strong caring adults and access to health and mental health services.	I	This initiative strengthens the ability of men and urban communities to positively influence boys.
5. **Disabilities & Health Program**: The DFH participated on a statewide Transition Council to ensure that CSHCH who are moving from high school to adulthood have the skills and supports they need to be productive in the community.	I	The Transition Council is a multi-departmental effort to create policies and maximize resources to improve outcomes for this population. Five regional centers were established to provide training and support for school staff and a survey was conducted to collect data that can be used to increase this population's access to services. The survey produced a baseline that can be used with future surveys.
6. **Adolescent Media Campaign**: The DFH developed a plan for a statewide media campaign using the theme "Be There For Teens, Help Them Succeed", with the first year message being "Talk to Teens, It Can Make a Difference".	P	The DFH plans to launch the campaign in January 2001. Recent research shows a correlation between school success and good communication with caring adults. All materials have been produced in English and Spanish.
7. **Healthy Child Care**: The DFH supported parenting classes in childcare settings on developmental topics impacting children, including adolescents.	E	A significant number of middle school age youth are home after school, without adult supervision, more than three hours one to two days per week. After school care continues to be in short supply in Rhode Island, especially for children ages 11-14. The DFH's participated on the statewide Starting Right Implementation Committee, which expands the existing child care subsidy program to include after-school programs for youth.
8. **Immunization Program:** The DFH conducted a "Vaccinate Before You Graduate" program targeting high school seniors.	I	A pilot project in the racially/ethnical diverse Pawtucket School-Based Health Centers (SBHCs) vaccinated 167 seniors for Hepatitis B, Td, MMR, and meningitis.

TABLE 54
Programs/Activities Needing Review/Revision for SPM #6
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Town Teen Network**: The Town Teen Network Program ended with the creation and implementation of the state's Starting Right initiative.	I	The DFH supported the state's Starting Right initiative, which will expand the existing childcare subsidy program to adolescents in after-school settings. Start-up funds were distributed to support community agencies providing after-school programs. As a result, the Town Teen Network initiative will not be included in the DFH's Title V plan for 2001. The DFH, however, will continue to work to address statewide funding issues.
6. **Adolescent Media Campaign (*):** The Campaign is a new initiative less than 2 years old.	P	
8. **Immunization Program (*):** The "Vaccinate Before You Graduate" pilot is a new initiative less than 2 years old.	I	The DFH plans to expand this project to other communities in the future.

* = programs/activities that are new within the past 2 years.

SPM #7 –Number of Children with Individualized Family Service Plans (IFSP) for whom an Individual Education Plan (IEP) is developed.

Status of Annual Performance Indicator: 71.4
Indicator: ( ) is new (X) has improved ( ) has stayed the same ( ) has not improved

Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: Early Intervention Program

State Priority Need Being Addressed: Assure access to appropriate services during periods of transition for CSHCN and other children.

Population(s) served: ( ) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 55. Programs to be reviewed or revised are in Table 56. See page 187 for FY 2001 annual plan for this measure.

TABLE 55
Programs/Activities Contributing to Success of SPM #7
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Early Intervention (EI) Program**: The DFH's regional EI programs provided comprehensive transition services for CSHCN who will be turning three years old.	I	The DFH's regional EI programs establish annual transition goals to assure that timelines specified in IDEA are appropriately met. Transition planning for IEP development begins on or before a child's 30th month of life and is completed by the child's 36th month. Regional meeting occur on an on-going basis to address systems issues related to transition, and this information is shared with the Inter-Agency Coordinating council and included in its annual report. The DFH & the Department of Education have ongoing work to assure appropriate transition.
2. **Parent-Consultant Program**: DFH parent consultants in the regional EI supported families with CSHCN at meetings and inform families about procedural safeguards.	I	Through EI's comprehensive systems personnel development (CSPD) efforts and Parent-Consultant meetings, the role of the parent to enable the families within EI has been discussed.
3. **Disabilities & Health Program**: The DFH worked closely with the Department of Education and the Rhode Island Transition Council to conduct on-going surveys on transition issues, which included medical home and oral health components.	I	Currently, the DFH is advocating for the existing school-to-work transition plans to include the primary care (i.e. "medical home") needs of this population.

TABLE 56
Programs/Activities Needing Review/Revision for SPM #7
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments

SPM #7: There are no activities needing revision at this time.		

* = programs/activities that are new within the past 2 years.

SPM #8 –Number of children in WIC age less than 5 with a length for weight that is less than or equal to the 10th percentile or greater than or equal to the 90th percentile.

Status of Annual Performance Indicator: 24.3
Indicator: (X) has been revised ( ) has improved ( ) has stayed the same (X) has not improved

Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: WIC Program

State Priority Need Being Addressed: Improve the nutritional status of children, youth, and their families.

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 57. Programs to be reviewed or revised are in Table 58. See page 188 for FY 2001 annual plan for this measure.

TABLE 57
Programs/Activities Contributing to Success of SPM #8
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Family Resource Counselor (FRC) Program**: Culturally diverse FRCs screened all children and pregnant women presenting for care at community health centers and hospital-based clinics and referred them to WIC, as appropriate.	E	The DFH supported FRCs in 13 community health centers and 3 hospitla outpatient clinics. The majority of these sites are located in racially/ethnically diverse urban communities.
2. **Home Visiting Program**: Home Visitors referred families to WIC and provided families with culturally appropriate nutrition & feeding education.	E	About 40% of the families who were served through the DFH's Home Visiting Program in 1999 were minorities.
3. **WIC Program**: The WIC Program screened for normal growth patterns of children and provided nutritious supplemental foods and consumer-friendly culturally appropriate information and education to families in WIC.	E	WIC Program data indicate that during 1999, 2.5% of infants and 3.2% of children participating in the WIC Program were underweight. During the same year, 20% of infants and 21.5% of children were overweight. Standards were revised. WIC provided specialized food packages based on participants needs and educated WIC families about basic nutrition and the importance of physical activity. Improvements in the local economy, welfare reform, and changes in food stamp eligibility may have contributed to a downturn in WIC participation.
4. **WIC Media Campaign**: The DFH conducted a comprehensive needs assessment that included a series of focus groups with current users and non users of WIC services, community-based agency staff who refer to WIC, and DFH WIC Program staff.	P	A proposed strategy was presented to the WIC Program to reposition the program's efforts and focus on customer servcies strategies to increase participation. The DFH plans to target working, non-English speaking families in private physician's offices in its efforts to increase WIC enrollment. Development of the campaign will take place in 2001.
5. **Parent Consultant Program**: The DFH	E	The WIC Program's parent-consultants are culturally

supported parent-consultants in the WIC Program to review & create culturally appropriate printed nutrition education and outreach materials for families in WIC.		diverse.
6. **Farmer's Market Nutrition Program (FMNP):** The DFH provided low-income families with access to fresh fruits and vegetables.	E	During 1999, 12,192 individuals received FMNP benefits. All FMNP customers received helpful hints on shopping for fresh produce and recipes for storage and preparation of produce. Participant surveys were done to determine customer satisfaction with the FMNP.

TABLE 58
Programs/Activities Needing Review/Revision for SPM #8
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
SPM #8: National WIC risk criteria redefined overweight ($\geq 90^{th}$ percentile H/W) and underweight ($\leq 10^{th}$ percentile H/W) for children's WIC risking.	I	SPM #8 was modified to reflect this change to: The number of infants and children in the WIC Program with statures for weight that are either $\leq 10^{th}$ percentile or $\geq 9O^{th}$ percentile. Previously, SPM #8 was as follows: Number of children in WIC less than 1 with a length for weight $\leq$ the 25^{th} percentile or $\geq$ the 90^{th} percentile and number of children in WIC between the ages of 1 and 5 with a length for weight that is either $\leq$ the 10^{th} percentile or $\geq$ the 95^{th} percentile.

* = programs/activities that are new within the past 2 years.

SPM #9 –Number of at risk newborns who receive a home visit in the early newborn period (up to 90 days after birth).

Status of Annual Performance Indicator: 53.2
Indicator: ( ) is new ( ) has improved (X) has stayed the same ( ) has not improved

Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: Home Visiting Program Database

State Priority Need Being Addressed: Assure that families participate in MCH program activities through intensive outreach efforts.

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 59. Programs to be reviewed or revised are in Table 60. See page 189 for FY 2001 annual plan for this measure.

TABLE 59
Programs/Activities Contributing to Success of SPM #9
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Newborn Screening Program**: The DFH determined risk factors and made referrals to the Home Visiting Program.	I	The DFH defined the early newborn period as being up to 90 days after an infant is born. It chose this period because most premature and low birthweight infants are not discharged from the hospital immediately after birth.
2. **Home Visiting Program**: The DFH	I	54% of newborns qualified for visits in Rhode Island.

provided home visiting services to families who had a risk suspect newborn.		Visits are voluntary, but if the family accepts the visit, they are seen within a few days of discharge. Priority referrals are seen within 24 hours of discharge and referrals are made, as needed, for all children.
3. **KIDSNET**: The DFH utilized KIDSNET to tracked newborn screening and home visiting data.	I	KIDSNET now tracks all at risk newborns to assure that they have a Level II screening and referral to Early Intervention, as appropriate.
4. **Early Intervention (EI) Program**: The Home Visiting Program was an important source of referral for children eligible for EI.	I	Children enrolled in EI, in most cases, receive home visits from EI service coordinators on an on-going basis.
5. **"Parents As Partners" SSDI initiative**: This systems development initiative helped "hard-to-reach" families access home visiting services.	I	12% of the "hard-to-reach" families in the racially and ethnically diverse urban communities of Woonsocket and Central Falls who participated in this initiative reported that they utilized DFH home visiting services after they received education from culturally diverse local "peer parents".

TABLE 60
Programs/Activities Needing Review/Revision for SPM #9
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
5. **"Parents As Partners" SSDI Initiative:** The DFH's SSDI Initiative ended in early 2000**.**	I	The DFH will utilize 2000 and 2001 to expand the "Parents As Partners" model to Providence.

* = programs/activities that are new within the past 2 years.

SPM #10 –Number of completed family surveys.

Status of Annual Performance Indicator: 1,000
Indicator: (X) has been revised (X) has improved ( ) has stayed the same ( ) has not improved

Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: Rhode Island Food Security Monitoring Project (RIFSMP), "Parents As Partners" SSDI Initiative, Healthy Child Care, & WIC Program

State Priority Need Being Addressed: Increase community and family feedback and involvement regarding MCH program services and priorities.

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 61. Programs to be reviewed or revised are in Table 62. See page 190 for FY 2001 annual plan for this measure.

TABLE 61
Programs/Activities Contributing to Success of SPM #10
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **"Parents As Partners" SSDI Initiative**: The DFH's SSDI initiative supported parent-consultants to develop and implement a needs assessment to determine why	I	Information was obtained through key informant (provider) interviews, in-person and telephone parent surveys, and focus groups. Data was analyzed by the parent-consultants and recommendations were made to DFH program staff through the DFH's Management Team Meeting. Presently, the recommendations are in the process of being implemented with a goal of assuring greater participation in DFH programs.

potentially eligible families in Woonsocket & Central do not participate in DFH programs.		
2. **Rhode Island Food Security Monitoring Project (RIFSMP)**: The RIFSP was established in 1999 to assess and monitor the prevalence of hunger and food insecurity among households residing in poverty areas across the state.	I	During the Spring of 1999, the DFH conducted a telephone survey of 410 households randomly selected from the 41 poverty census tracts in Rhode Island. Results of the pilot were officially released in October 1999. The survey is being repeated during Spring of 2000 and 400 responses are anticipated. Having the capacity to document and monitor the prevalence of hunger in the state is a critical component of its long-term efforts to improve food security in Rhode Island.
3. **Healthy Child Care**: The DFH conducted a survey of families with young children in licensed childcare facilities.	I	The survey was conducted in June of 1999, and a total of 302 responses were received.
4. **WIC Program**: The DFH conducted a statewide survey of WIC participants.	I	The DFH conducts this survey of about 1,000 WIC participants on an annual basis. About 70% of the respondents consistently report that they fear that they will run out of money for food in the near future.
5. **Parent Consultant Program**: The DFH's parent-consultants and local parents were instrumental in spearheading the DFH's efforts to survey other parents and obtain other forms of input from them during the reporting period.	E	The DFH's parent-consultants assisted the DFH's Communications Unit by presenting their perspective and recruiting parents for focus groups and community meetings during the development of the DFH's public media campaigns for childhood lead poisoning prevention, immunization, and adolescent health. DFH parent-consultants also conducted outreach to families on an on-going basis through their participation in health fairs, community presentations, and parent-to-parent support.

TABLE 62
Programs/Activities Needing Review/Revision for SPM #10
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
SPM #10: SPM #10 has been revised to read as follows: the number of completed family surveys.		SPM #10 used to read as follows: the number of completed parent surveys.

* = programs/activities that are new within the past 2 years.

2.5 Progress on Outcome Measures
Please refer to Form 12 in Supporting Documents Section 5.8.

Outcome Measure #1 – The infant mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 6.9 *(Same number documented on Form 12)*
Indicator Has: (X) Improved ( ) Not Improved
Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: MCH Database

Outcome Measure #2 – The ratio of black infant mortality rate to white infant mortality rate.

Status of Annual Outcome Indicator: 3.2 *(Same number documented on Form 12)*
Indicator Has: ( ) Improved (X) Not Improved
Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: Linked Birth/Death File

Outcome Measure #3 – The neonatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 5.7 *(Same number documented on Form 12)*
Indicator Has: ( ) Improved (X) Not Improved
Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: Linked Birth/Death File

Outcome Measure #4 – The postneonatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 1.1 *(Same number documented on Form 12)*
Indicator Has: (X) Improved ( ) Not Improved
Objective Met/Exceeded: (X) Yes ( ) No

Source of Data: Linked Birth/Death File

Outcome Measure #5 – The perinatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 10.2 *(Same number documented on Form 12)*
Indicator Has: (X) Improved ( ) Not Improved
Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: Linked Birth/Death File

Outcome Measure #6 – The child death rate per 100,000 children aged 1-14.

Status of Annual Outcome Indicator: 17.4 *(Same number documented on Form 12)*
Indicator Has: ( ) Improved (X) Not Improved
Objective Met/Exceeded: ( ) Yes (X) No

Source of Data: MCH Database

2.5 Progress on Outcome Measures (see also Form 12)

Infant Deaths

Outcome Measure 1: Infant mortality rates, including neonatal and postneonatal, in Rhode Island have fluctuated from year to year due the small number of births and infant deaths in Rhode Island. However, the overall trend of infant mortality in Rhode Island has been one of decline. In 1996, Rhode Island's occurrence infant mortality rate was 5.6 (residence rate was 5.2), one of the lowest rates in the country and a rate well below the Healthy People 2000 goal of 7.0. However, provisional data for 1997, 1998 and 1999 illustrate the fluctuations in Rhode Island's infant mortality rates, where occurrence rates are estimated to be 7.1, 7.6 and 6.9, respectively; and resident rates for 1997,1998 and 1999 are projected to be 7.0, 7.0 and 5.5, respectively.

Outcome Measure 2: Substantial disparities have existed among different racial/ethnic groups, with higher rates reported for African Americans. These disparities have persisted over many years, with the rate for African Americans being about 1.5 to 2 times higher than the White rate. However, provisional occurrence data for 1999 indicate that the gap has widened. The occurrence infant mortality rate among African Americans in 1999 was 18.4, 3.2 times higher than the White rate of 5.7.

The gap between African American and White infant mortality rates is not as large when resident (Rhode Island residents only) infant mortality rates are considered. Provisional resident data indicate that the resident African American infant mortality rate has been approximately 1.5 times that of the White rate. For instance, in 1997, the resident rate for African Americans was 9.7 compared with 6.9 for Whites. Unfortunately, provisional data indicate the number of African American infant deaths rose in Rhode Island from 9 in 1997 to 14 in 1998. At the same time, there was a decrease in the number of infant deaths among Whites, from 74 to 69 deaths. As a result, the gap between African American and White infant mortality rates appears to have widened in 1998, where the African American rate was 2.3 times higher than the White rate. A review of the African American infant deaths that occurred in 1998 showed that the majority was due to prematurity and congenital anomalies.

The Healthy People 2000 Objective was 1.5 (White infant mortality rate of 7 and an African American rate of 11) and, as stated above, Rhode Island has achieved that objective in previous years. However, Rhode Island will be challenged to eliminate these disparities by 2010.

Outcome Measure 3: Provisional data for 1999 indicate that the occurrence neonatal mortality rate has risen since 1996, when the neonatal mortality rate was 4.4. Although Rhode Island achieved the Healthy People 2000 goal of 4.5 in 1996, by 1999, the neonatal rate had risen to 5.7, a 30% increase. Contributing factors to the rise in the neonatal mortality rate are the rise in the percentage of babies being born at low birth weights and the rise in multiple births. These factors are discussed briefly below and in more detail in the needs assessment, section 3.2.2.1.

Outcome Measure 4: The occurrence postneonatal infant mortality rate has been rising, although provisional 1999 data show a sharp decline from 1998. In 1996, the postneonatal mortality rate was 1.3 and by 1998 this rate had risen by 46% to 1.9. It appears that in 1999, the postneonatal rate decreased by 42% from 1998, to 1.1. Rhode Island has achieved the Healthy People 2000 Objective of 2.5 postneonatal deaths per 1,000 live births.

Outcome Measure 5: The perinatal mortality rate in Rhode Island has been rising , although provisional data for 1999 indicate a slight decrease. In 1996, the perinatal mortality rate was 7.8 and by 1999, the rate had risen to 10.2, a 31% increase. Rhode Island still has a long way to go in meeting the Healthy People 2000 Objective of 4.5.

Discussion:

Although the infant mortality rate has been fluctuating in Rhode Island, the percentage of women who begin their prenatal care in the first trimester has been rising (see NPM #18 and SPM #4). Rhode Island has achieved the Healthy People 2000 goal of 90%, where in 1999, 91.1% of women in Rhode Island stated they began their care in the first trimester. Nevertheless, during the 1990's, the percentage of babies born at low birth weight, particularly very low birth weight, has been increasing. According to provisional data, Rhode Island's rate of very low birth weight has risen over the past few years. In 1996, the very low birth weight rate was 1.1% and by 1998, the rate rose to 1.6%; provisional 1999 data indicate this figure has decreased to 1.5%. During the same time period, the percentage of babies born weighing 1500-2499 grams remained stable at 5.9%.

Efforts continue towards reducing the percentage of babies born at very low birth weights (NPM#15) and ensuring that very low birth weight babies are delivered at high risk facilities (NPM #17). The majority, 92.9%, of the very low birth weight babies was delivered at Women and Infants Hospital, the regional perinatal center.

The increasing rate of multiple births in Rhode Island is also a contributing factor to both the rise in low birth weight births and the fluctuation in infant mortality rates. In Rhode Island, a growing proportion of infant deaths is among multiple births. Of the 602 infant deaths that occurred during 1989-1993, 82 (13.6%) were among multiple births. During 1994-1998, 66 (16.5%) of the 399 infant deaths were among multiple births.

Providing home visits to newborns determined to be at risk for developmental risk factors through the Universal Newborn Screening (Level I) Program (SPM #9) can also contribute to a reduction in infant mortality. Families are provided referrals and follow-up, thereby, ensuring these infants receive the services they need.

Child Deaths (aged 1-14)

Outcome Measure 6: Although the number of child deaths in Rhode Island has been declining, provisional 1998 and 1999 data show slight increases. In 1994, 48 Rhode Island children aged 1-14 died and by 1997, the figure dropped nearly 50% to 27 deaths. Provisional data indicate that in 1998 and 1999, the number of child deaths rose to 31 and 33, respectively. The rate of child deaths (number of child deaths per 100,000) also had been decreasing. In 1994, the child death rate was 25.6 and by 1997, the rate had decreased by 42.6% to 14.7. However provisional data indicate that the rate increased 18.4% to 17.4 in 1999.

Because Rhode Island has relatively small numbers of deaths, year to year fluctuations are common. As the data have shown, six additional deaths which occurred between 1997 and 1999 resulted in an 18% increase in the child death rate. Therefore, aggregating five years of data are more statistically reliable and data for 1995-1999 are described below.

During the 1995-1999 period, a total of 158 (17.0 deaths per 100,000) Rhode Island children aged 1-14 died. Of these deaths, 103 (65.2%) were due to diseases; 9 (5.7%) resulted from homicide; and 1 (0.6%) was a suicide. The

remaining 45 (28.5%) of these deaths were accidental, 16 of which were due to motor vehicle accidents (see NP#8). The number of deaths resulting from motor vehicle accidents has remained stable. During 1995-1999, there were approximately 3 deaths per year.

There are disparities in child death rates among different racial/ethnic groups. During the five year period, 1995-1999, Asians and Whites had the lowest child death rates at 12.6 and 15.3, respectively. African Americans had the highest child death rate at 36.9, three times the Asian rate and more than twice the White rate. The child death rate was also high among Native Americans, where the rate was 25.5, twice the Asian rate. Children of Hispanic/Latino ethnicity had a rate (17.6) slightly higher than the White rate (15.3) and statewide rate (17.0).

The Division of Family Health works with families to help ensure they have access to a range of health and family support services critical to helping children grow into strong, healthy and productive adults. Children are at an increased risk if their parents or care givers are overwhelmed by multiple problems such as inadequate income, lack of a job or a decent place to live, emotional stress, isolation from extended family or friends, drug and/or alcohol abuse, mental illness, or domestic violence. Families benefit from access to comprehensive services that are able to flexibly respond to their needs. The Universal Newborn Screening (Level I) and Home Visiting Risk Response programs, as well as the Lead Poisoning Prevention and Immunization programs, play a significant role in identifying children at risk and providing families with home visits and referrals to health and social support services (see SP #1, #5 and #9). Another means to improving the health and safety of children are school-based health centers (see SP#2). Currently, Rhode Island has seven school-based health centers: 1 elementary school, 2 middle schools, and 4 high schools. They are located in four of the five core cities: Providence, Pawtucket, Central Falls and Woonsocket. Finally, ensuring that children have health insurance and a medical home (see NP #12 and #3) and thereby, access to a range of services will also contribute to a reduction in deaths among children aged 1-14.

III. REQUIREMENTS FOR APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

Data and Community Input

The Division's needs assessment process is one which relies on surveillance, parent and community input, and interagency collaboration. Utilizing data from our Women's Health Screening and Referral Program, Universal Newborn Risk Development Screening (Level I) and Home Visiting Risk Response databases provides us with a current picture of the needs of pregnant women, infants and their families. Vital Records data also allow us to track maternal and child health status indicators such as entry into prenatal care, low birth weight and infant mortality. Program databases such as WIC, Lead Screening, and Early Intervention provide us with information on children. Our KIDS NET system, described throughout our Annual Report and Application, is also key in tracking data related to children's preventive services, especially immunizations. Hospital discharge data, school-based health center data, the Youth Risk Behavior Survey, and School Accountability for Learning and Teaching (SALT) Survey are also examples of tools used to assess the well-being of Rhode Island's youth. Utilizing these data sources allows us to determine the trends and health status of the maternal and child population.

In addition, working closely with the Children's Cabinet agencies (e.g., Human Services; Education; and Children, Youth and Families) and with RI KIDS COUNT and other community organizations, provides us with a more comprehensive understanding of the well being of children and their families and the environment in which they live.

Finally, a key part of the needs assessment process is the involvement of parents and communities. Our needs assessment and the identification of emerging priorities rely heavily on parent/community input before, during and after the Title V Application's completion. By conducting this multi-pronged needs assessment process described above, we are able to obtain a wide breadth of information giving us a better understanding of the maternal and child health needs of families in Rhode Island. Section 3.1.2.1 below describes the results of this process. The section is organized by population group and by the priorities identified by the Division of Family Health.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population Status

The following overview is organized by maternal and child health (MCH) population groups, i.e., pregnant women and mothers, infants, children, adolescents and children with special health care needs. Topics are related to the priorities identified by the state. A brief discussion of the changes in these populations between 1990 and 1999 precedes the overview of the health status of the MCH populations in Rhode Island.

Population Changes in Rhode Island: 1990 and 1999

During the 1990's, Rhode Island's population declined slightly. In 1990, there were 1,004,665 Rhode Islanders and by 1999, the population dropped to just below one million, 990,819, a 1.4% decrease. Figures 3 and 4 show the Rhode Island population in 1990 and 1999 by gender and by selected age groups. Between 1990 and 1999, the population of children under 5 years of age in Rhode Island, decreased 9.3%. Changes in the number of births are

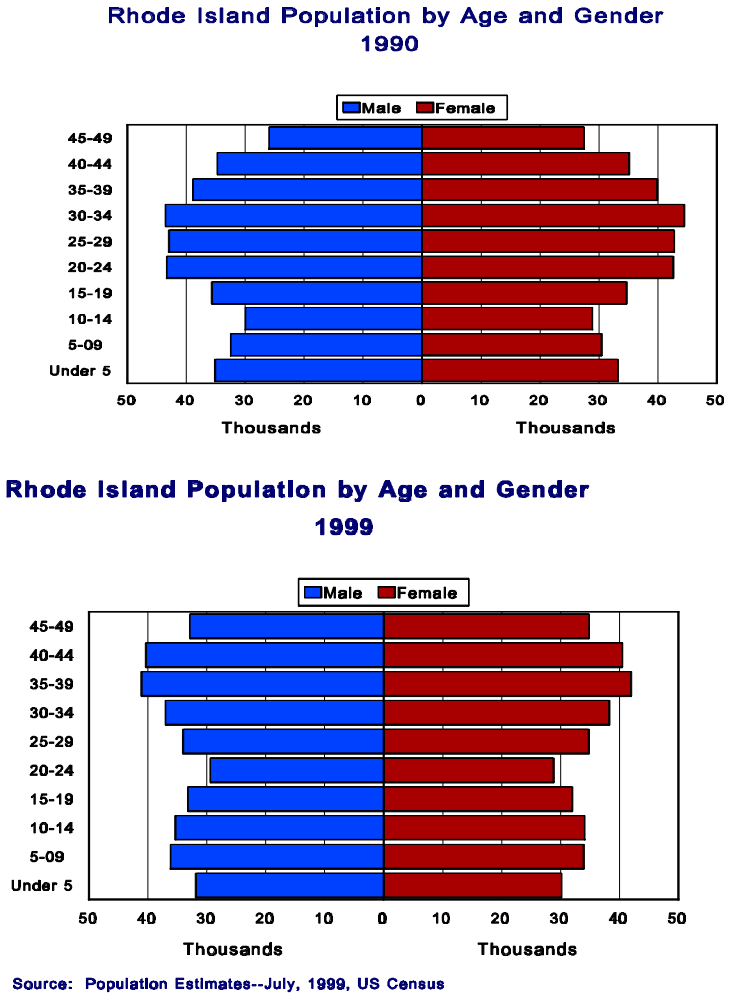
described in more detail in Section A1 below. Not all age groups experienced decreases, however; the number of children aged 5-9 and 10-14 increased during this period by 11.3% and 18%, respectively. Teens aged 15-19 decreased by 7.3%; and the number of female teens decreased 7.7%.

Overall, women of childbearing age (15-44) decreased 9.6%, from 239,605 in 1990 to 216,350 in 1999. Specifically, the number of women aged 20-24 decreased the most, 32.4%. However, women aged 35-39 and 40-44 increased by 5.1% and 15.3%, respectively.

Changes in population age groups impact the rates (number of health events divided by relevant population group) of births, diseases, deaths and other health-related events. For example, the same number of events (e.g., births) could occur during a given period, but if the population decreases during this time, the rates will increase.

Figure 3

Figure 4



A1. Pregnant Women and Mothers

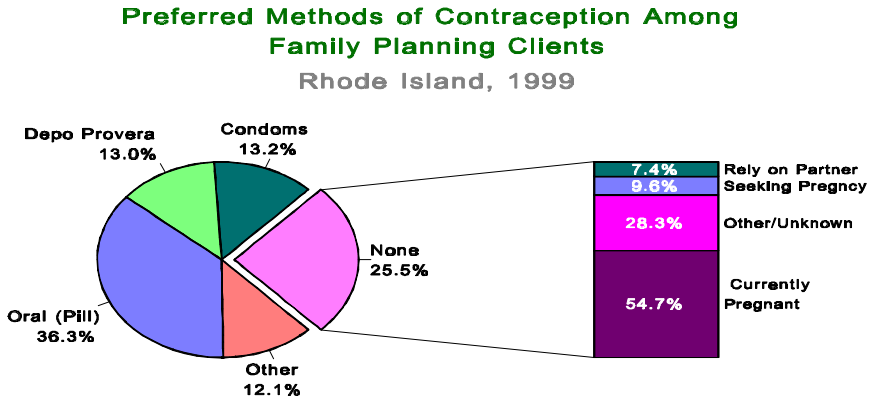
PRIORITY: REDUCE AND MANAGE PREGNANCY RISKS

Family Planning/Birth Control

During Calendar Year 1999, 12,099 clients were seen at Rhode Island's Title X-funded family planning clinics. Of these, 1,588 (13.1%) were aged less than 18; 7,690 (63.6%) had public insurance; 9,542 (78.9%) were at or below 100% of the Federal Poverty Level; 6,651 (55.0%) were White; 902 (7.5%) were African American; 460 (3.8%) were Asian; and 3,474 (28.7%) were Hispanic.

Figure 5 shows the most preferred methods of contraception (as of 12/31/99) among those seen at family planning clinics and reasons for not using contraceptives. The most preferred methods were: the pill, used by 4,397 (36.3%); condoms, used by 1,593 (13.2%); and depo provera, used by 1,574 (13.0%). However, 3,087 (25.5%) of the clients stated they did not use any contraceptives. The main reasons given for not using contraceptives were: currently pregnant (1,690 or 54.7%); seeking pregnancy (296 or 9.6%); and rely on partner (229 or 7.4%).

Figure 5



Source: Family Planning Program
Division of Family Health, Rhode Island Department of Health

By comparing the contraceptive methods reported at the first clinic visit and the contraceptive methods used at the last visit during the 1999 period, the number of pregnancies averted among family planning clinic clients may be estimated using the expected rate of pregnancies for each method (developed by Ahlers and Associates). The rate of expected pregnancies per 1,000 clients for each type of contraceptive multiplied by the number of clients using each method yields the number of expected pregnancies. Based on first clinic visit data and contraceptive methods used among 6,524 clients, a total 2,194 pregnancies were expected. However, by the time of their last visit during 1999, only 1,350 pregnancies were expected or 844 pregnancies were averted. This is due to an increase in the number of clients using contraceptives and the specific contraceptive method chosen.

Identification of Risks Among Women Receiving Pregnancy Tests

In 1997, the Rhode Island Women's Health Screening and Referral Program (WHSRP) was developed to address four important health objectives: 1) to prevent unintended pregnancies; 2) to improve pregnancy outcomes by identifying risks and appropriate follow-up; 3) to identify gaps in the existing services delivery system; and 4) to create a risk responsive continuum of care for all women, regardless of pregnancy status.

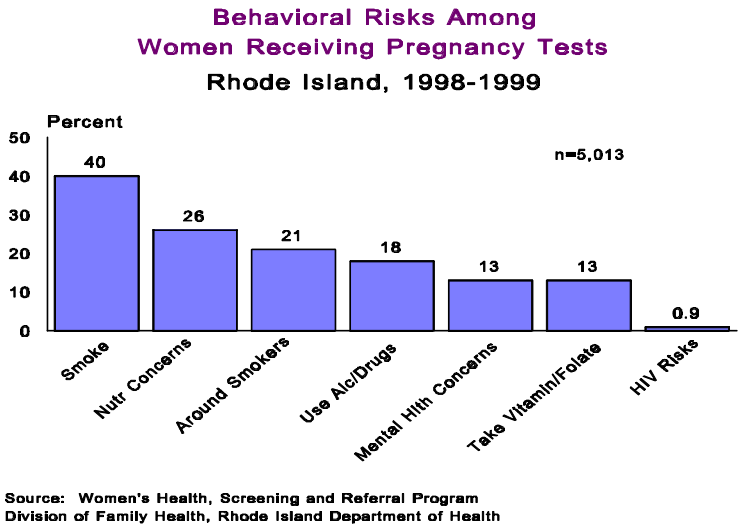
Following a pilot in several Title X family planning clinics and private Ob/Gyn practices, the WHSRP was expanded to ten Title X family planning clinics in 1998. The clinics are located in high need communities, where there are large concentrations of poverty and other public health concerns. As described above in the "Family Planning" section, the clinics serve approximately 12,000 patients each year. All women participating in the WHSRP receive a pregnancy test at no cost and they are asked to complete an eighteen-item questionnaire, called the "*Care Questionnaire*", while they wait for their pregnancy test results. The *Care Questionnaire* was designed by a partnership of family planning, obstetrical, and primary care professionals to flag significant risks to a woman's health and pregnancy status.

Women who are identified with one or more risks are provided with education and may be referred to any of the following services depending on their pregnancy status: family planning, smoking cessation, substance abuse assessment, nutrition services, social services, domestic violence assistance, HIV/STD screening, mental health services, genetics counseling, community action programs, home visiting, immunization, and medical/prenatal care.

Of the 5013 *Care Questionnaires* that were completed during 1998 and 1999, (44%) of the pregnancy tests were positive; (54.0%) had a negative pregnancy test; and results were unkown for (2%). More than three-quarters (78%) of the 5013 women reported their suspected pregnancy was unplanned, and only 34% were utilizing a birth control method at the time of the suspected conception. Still, 69% reported that if their pregnancy test were positive, they would keep the baby.

The *Care Questionnaire* includes seven medically-related risks; six behavioral; and five psychosocial risks. In the medical risk category, 33% of the women stated they did not know their rubella immunization status; 14% had medical problems; 10% had a family history of birth defects and/or mental retardation; and 10% had previous pregnancy complications (Figure 6).

Figure 6



In the behavioral risk category, 86% reported that they were not taking a multivitamin with folic acid; 40% smoked tobacco and 21% were around someone else who smoked; 18% reported alcohol and/or illicit drug use; 26% had concerns about nutrition; and 14% indicated they were depressed or had some other mental health concerns (Figure 7) . In the psychosocial risk category, 15% stated they had no one to rely on at home and 12% said they had transportation and/or child care problems that affected their medical visits (Figure 8).

Figure 7

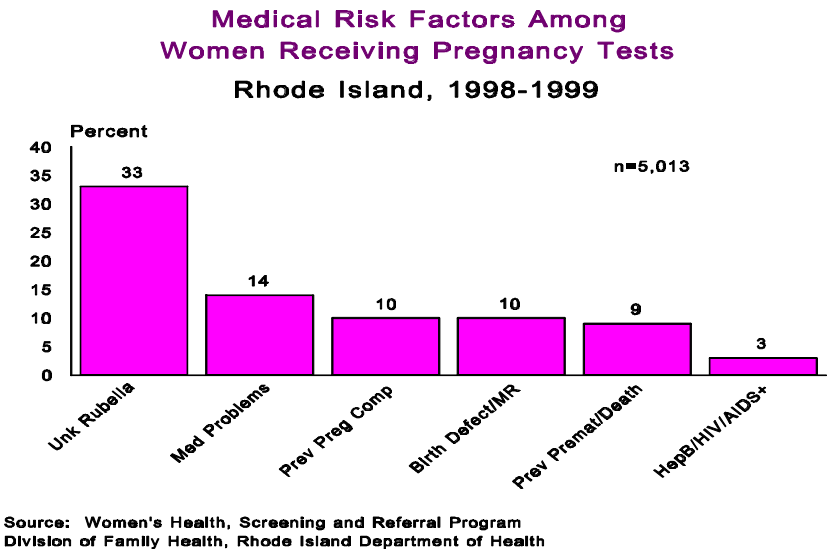
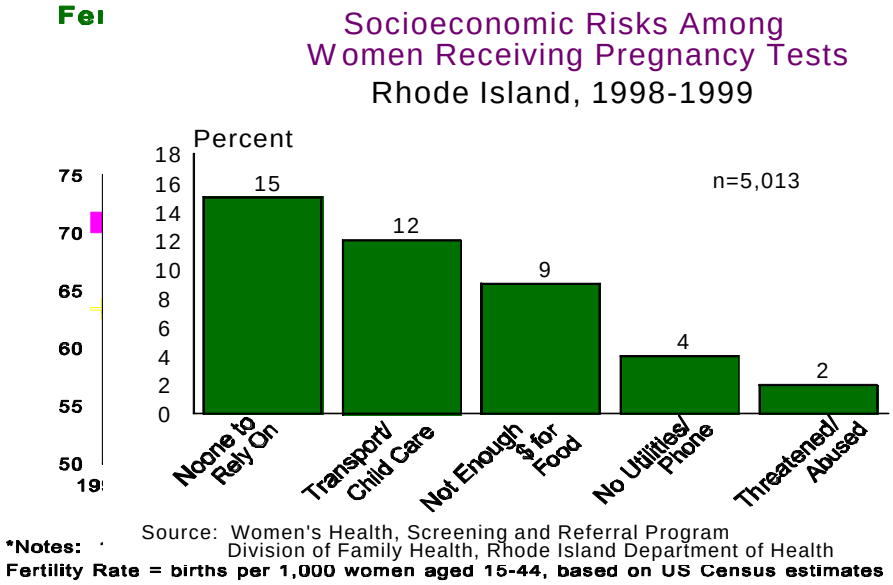


Figure 8



Pregnancies/Births/Fertility Rates

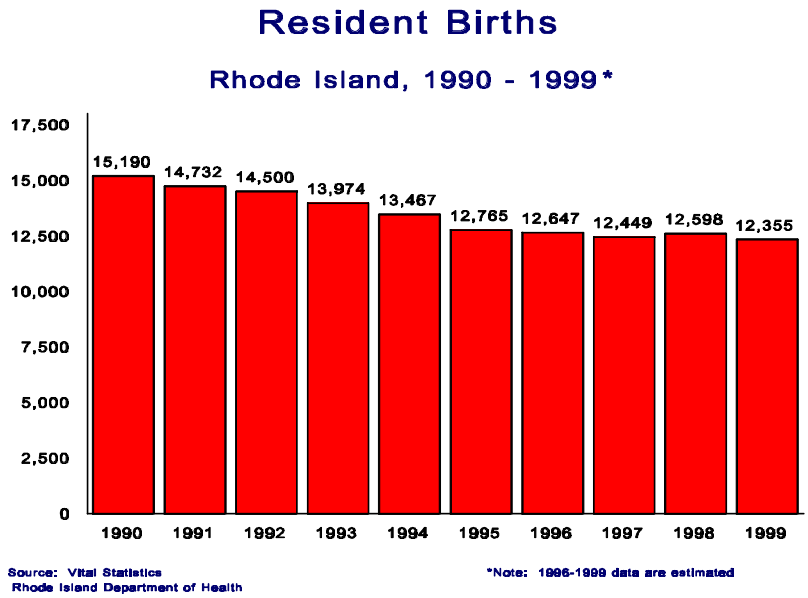
Rhode Island has seen a decrease in the number of pregnancies (live births, induced abortions, and spontaneous abortions) among its residents. Between 1990 and 1999, provisional data indicate the total number of pregnancies among women of all ages decreased by 25.5%, from 22,922 to 17,071. In 1999, among women of childbearing age (15-44 years), there were a total of 16,987 pregnancies, of which there were: 12,355 live births, 3,762 induced abortions, and 898 spontaneous abortions. The pregnancy rate among women of childbearing age has decreased from 92.8 per 1,000 women in 1990 to 78.5 in 1999, a 15.4% decrease. During 1990-1999, live births decreased among women of childbearing age by 18.7%, induced abortions by 37.6%, and spontaneous abortions by 9.4%.

The number of births and the fertility rate among women of childbearing age have been decreasing in both the United States and Rhode Island since 1990. However, national data indicate that in 1998, the number of births and the fertility rate rose in the country for the first time since 1990. Figure 9 compares the fertility rates of the United States and Rhode Island during the 1990□s, where Rhode Island□s rates have been lower and decreases in the rates sharper. The rate of decrease in births among Rhode Islanders may be higher than that of the United States because the number of women of childbearing age in Rhode Island has also been decreasing. Between 1990 and 1999, the number of women of childbearing age in Rhode Island decreased 9.5%. During this period the fertility rate decreased 10.1%, from 63.4 in 1990 to 57.0 in 1999. Between 1997 and 1998, the Rhode Island fertlity rate rose 1.6% (from 56.4 to 57.3), mirroring the national trend. However, preliminary data indicate that the fertility rate declined in 1999.

Figure 9

Similarly, the total number of births among Rhode Island residents rose (1%) in 1998, although provisional data for 1999 indicate that births have continued the overall trend of decline. Figure 10 shows there were a total of 15,190 births among Rhode Island residents in 1990 and by 1999 the number of births had dropped to 12,355.

Figure 10



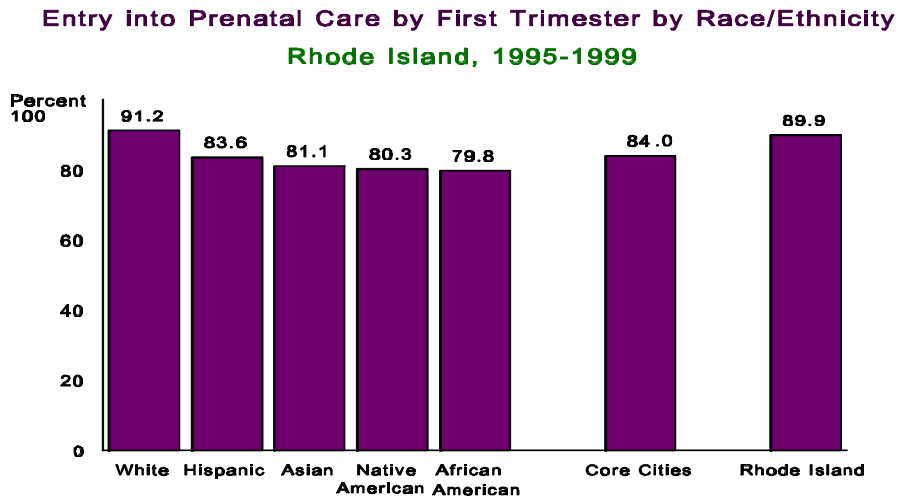
Since 1990, births have been decreasing among teens aged 15-19 and women aged 25-29, and increasing among women aged 20-24 and 30 and older. The age-specific fertility rate for teens aged 15-19 decreased 8%, from 44.6 in 1990 to 41.0 in 1998. Among women aged 25-29, the fertility rate decreased 25%, from 117.8 in 1990 to 88.3 in 1998. Women aged 40-44 experienced the largest increase, 55%, in their overall fertility rate between 1990 and 1998. Fertility rates among women aged 20-24 and 30-39, rose by 4% and 11%, respectively. Although the number of births among women aged 45 and older is very small in Rhode Island, they too

have been on the rise, from 5 births in 1990 to 16 in 1998; the birth rate among these women rose 157%.

Prenatal Care

More pregnant women in Rhode Island are receiving their prenatal care in the first trimester. In 1990, 86.7% of pregnant women received prenatal care in the first trimester and by 1999, the figure had increased to 91.4%. These figures are derived from self-reported data on the birth certificate. Although the 1999 rate surpasses the Healthy People 2000 goal of 90%, the rate of early entry into prenatal care varies among different population groups. For example, Figure 11 shows that during the five-year period 1995-1999, 89.9% of pregnant women received prenatal care in the first trimester. However, only 80% of African Americans and Native Americans, 81% of Asians, and 84% of Hispanics received prenatal care in the first trimester compared with 91% of Whites. Rates also differed among those living in lower socioeconomic areas, such as Central Falls (78%), and other core cities, and those living in higher socioeconomic communities, such as Barrington (97%). Overall, during 1995-1999, 84% of those living in Rhode Island's core cities received their prenatal care in the first trimester.

Figure 11



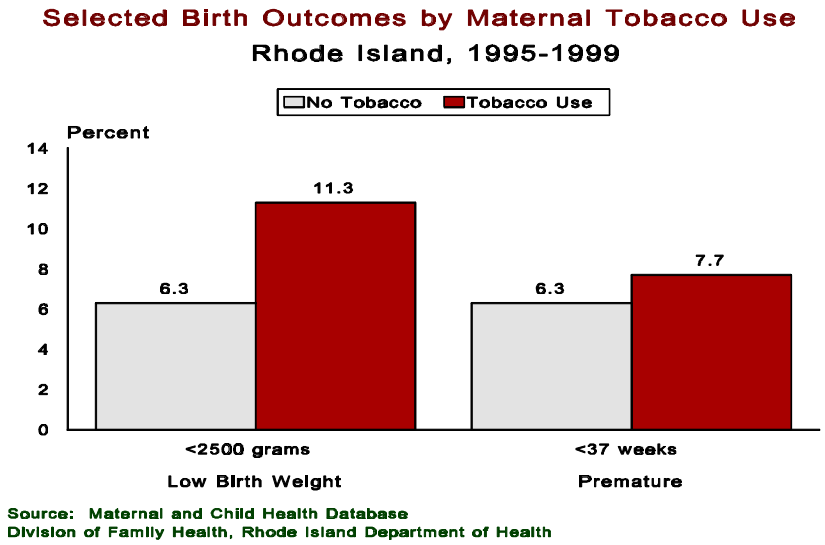
Source: Maternal and Child Health Database
Division of Family Health, Rhode Island Department of Health

Tobacco Use During Pregnancy

Babies born to women who smoke while pregnant are at a higher risk for adverse birth outcomes, including low birth weight (less than 5.5 lbs) and prematurity (less than 37 weeks gestation). Rhode Island birth certificate data indicate that nearly one in six women who gave birth during the five year period, 1995-1999, stated they had smoked cigarettes while pregnant. During this period, there were 62,814 live births, and mother's smoking status was determined for 60,873 (96.9%). Nearly 16%, (n=9,551) of babies were born to women who reported they smoked while pregnant.

Figure 12 compares the rates of low birth weight and prematurity among smokers and non-smokers. Women who smoked were nearly twice as likely to deliver a low birth weight baby than those who did not. During 1995-1999, 11.3% of babies born to women who smoked were born at low birth weights compared with 6.3% of babies born to women who did not. Similarly, during this period there were differences in rates of prematurity among women who smoked and those who did not, where 7.7% of women who smoked delivered premature babies compared with 6.3% of women who did not smoke while pregnant.

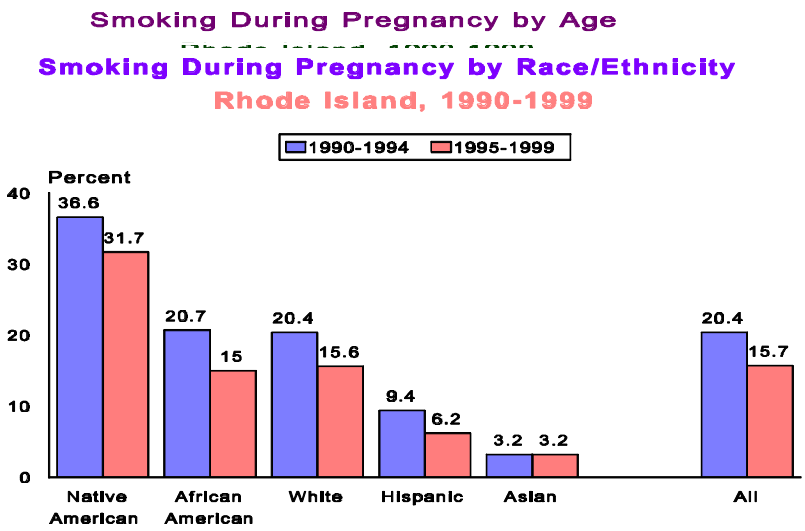
Figure 12



Over the past ten years, the rates of tobacco use among pregnant women have been decreasing in Rhode Island, paralleling the country's trend. In 1990, 22.5% of pregnant women smoked and by 1999, the rate had dropped to 13.5%. However, Rhode Island's rates have been higher than national rates. During 1991-1995, Rhode Island's rate was 19.3% compared with the national rate of 15.8% for the same period. Nevertheless, the gap between Rhode Island's rate and the country's has been narrowing. By 1998, the national rate had dropped to 12.9% and Rhode Island's rate to 14.8%.

Although smoking rates among women during pregnancy have varied by age and race/ethnicity, they have declined among all age groups and, with the exception of Asians, all racial and ethnic groups. Figure 13 below compares smoking rates during pregnancy among different age groups for the 1995-1999 period. The percentage of women who use tobacco during pregnancy decreases with age. Teens aged 15-19 and women aged 20-24 had the highest rates of smoking during pregnancy, where 23.0% and 21.9% respectively, smoked while pregnant. Women aged 40 and older had the lowest rate (9.0%) of smoking during pregnancy.

Figure 13



Source: Maternal and Child Health Database
Division of Family Health, Rhode Island Department of Health

When comparing the 1990-1994 and 1995-1999 periods, the rates of tobacco use among pregnant women in Rhode Island decreased by 23%. Although rates decreased among women in all age groups, women aged 30-34 experienced the largest decrease, where rates decreased 28.4%. Women aged 40 and older experienced the next largest decrease in smoking rates during pregnancy, at 26.8%. Table 62 below compares the changes in smoking rates among different age groups.

Table 62: Percent of Mothers who Smoked During Pregnancy and Percent Change by Age of Mother Rhode Island, 1990-1994 and 1995-1999

Age Group	1990-1994	1995-1999	%Change
15-19	26.4	23.0	-12.9
20-24	27.9	21.9	-21.5
25-29	18.9	14.9	-21.2
30-34	14.8	10.6	-28.4
35-39	12.8	11.0	-14.1
40+	12.3	9.0	-26.8
All Ages	20.4	15.7	-23.0

Figure 14 below compares the rates of smoking during pregnancy among racial/ethnic groups during the 1995-1999 period. Native Americans had the highest rate (31.7%) of smoking during pregnancy. Whites and African Americans had rates of 15.6% and 15.0%, respectively, close to the statewide average of 15.7%. Asian Americans and those of Hispanic/Latino ethnicity had the lowest rates of smoking during pregnancy at 3.2% and 6.2%, respectively.

Figure 14

When comparing the 1990-1994 and 1995-1999 periods, rates of tobacco use during pregnancy decreased among all racial/ethnic groups, with the exception of Asians, for whom the rate did not change. Hispanic/Latinos and African Americans experienced the largest change, where rates decreased by 35.4% and 27.5%, respectively. Table 63 shows the changes in rates of smoking among mothers during pregnancy by race/ethnicity for the 1990-1994 and 1995-1999 periods.

Table 63: Percent of Mothers who Smoked During Pregnancy and Percent Change by Race/Ethnicity Rhode Island, 1990-1994 and 1995-1999

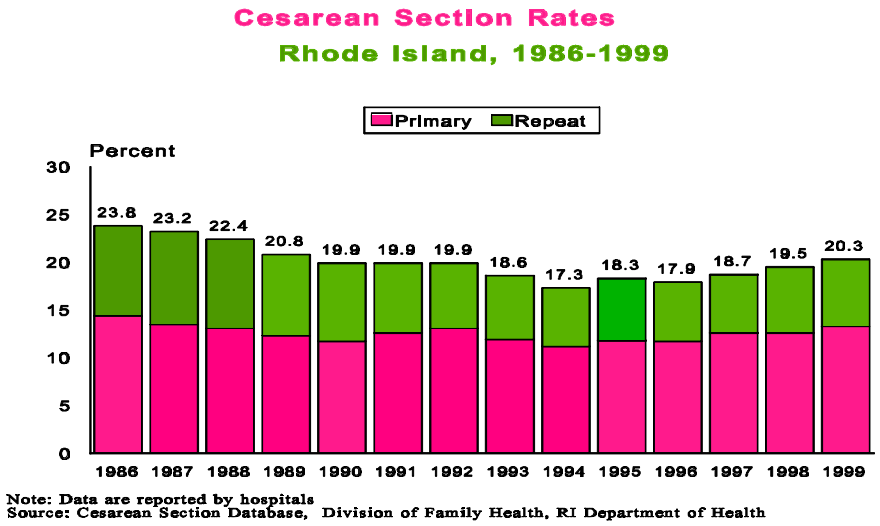
Racial/Ethnic Group	1990-1994	1995-1999	% Change
Native American	36.6	31.7	-13.4
African American	20.7	15.0	-27.5
White	20.4	15.6	-23.5
Hispanic/Latino	9.4	6.2	-35.4
Asian	3.2	3.2	0.0
All Rhode Island	20.4	15.7	-23.0

Cesarean Section Deliveries

During the late 1980's and early 1990's, the rate of cesarean section deliveries in Rhode Island decreased. In 1986, 23.8% of deliveries in Rhode Island were by c-section (3,166 c-sections among 13,284 deliveries) and by 1994, this figure dropped to a low of 17.3% (2,452 c-sections among 14,198 deliveries). Data indicate this downward trend has shifted and during 1995-1999, the c-section rate rose in Rhode Island (Figure 15). In 1999, 20.3% (2,626 c-sections among 12,919 deliveries) of deliveries in Rhode Island were by c-section, this represents the same proportion

as ten years previously, in 1989.

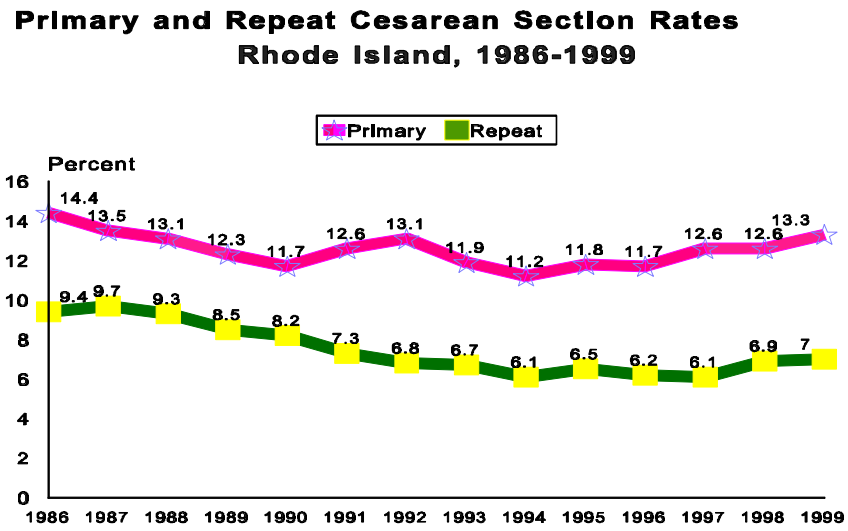
Figure 15



The primary and repeat c-section rates, which comprise the total c-section rate, have continued to change over the years (Figure 16). For instance, in 1986, the primary and repeat c-section rates were 14.4% and 9.4%, resepctively; by 1994, these rates had dropped to 11.2% and 6.1%. Since 1994, the primary rate has been increasing and by 1999, it had risen to 13.3%. The repeat c-section rate started rising more recently, as of 1998, and by 1999, it had increased to 7.0%. This indicates that the rate of vaginal births after c-sections (VBACs) has begun to decline.

The rate of c-section among individual hospitals in Rhode Island has varied and in 1999, rates varied from a low fo 16.1% to a high of 22.2%.

Figure 16

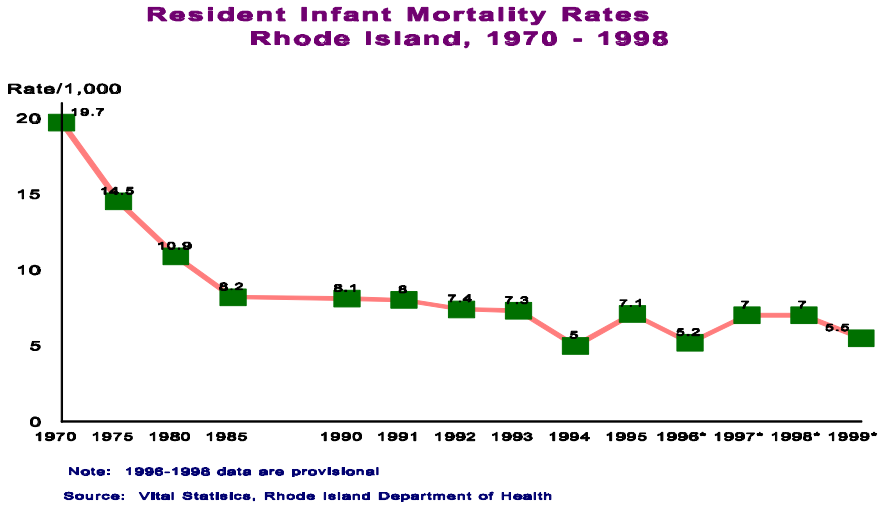


A2. Infants

Infant Mortality

Rhode Island's small population (and relatively small number of infant deaths) results in infant mortality rates that fluctuate from year to year (Figure 17); however, the overall trend has been one of decline. In both 1994 and 1996, with resident infant mortality rates of 5.0 (68 deaths) and 5.2 (66 deaths), respectively, Rhode Island's rates were among the lowest in the country. However, provisional data for 1997 and 1998, indicate there were approximately 20 more infant deaths in those years than for 1994 and 1996, resulting in infant mortality rates of 7.0 for both years. Preliminary data for 1999 again demonstrate the fluctuations in Rhode Island's infant mortality rates, where the number of infant deaths decreased to 68, yielding a rate of 5.5.

Figure 17



Substanti

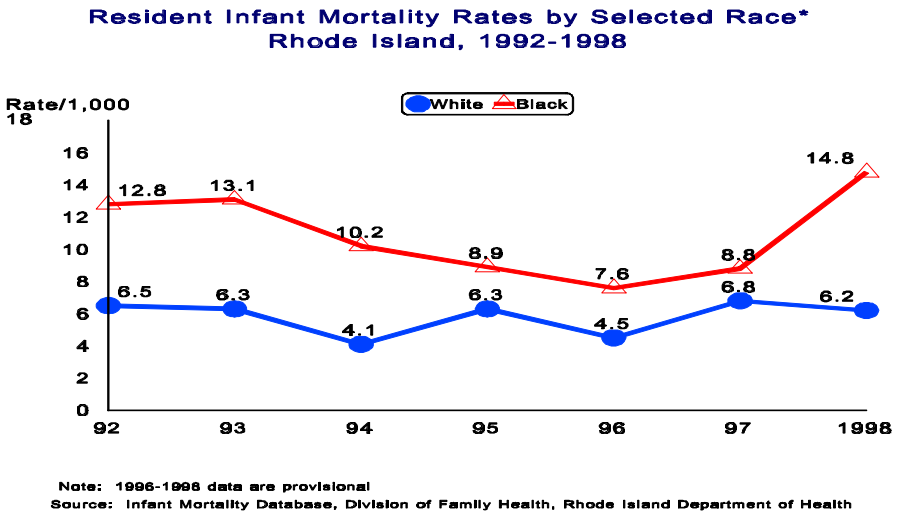
al disparities exist among different racial/ethnic groups, with higher rates reported for African Americans and lower rates among Asians and those of Hispanic/Latino ethnicity. These disparities have persisted over many years, and the rate for African Americans has remained about 1.5 to 2 times higher than the White rate (Figure 18). Although during 1995-1997, the gap appeared to be narrowing, preliminary data for 1998 indicate that the infant mortality rate for African Americans was more than twice the rate for Whites, 14.8 compared with 6.2. This difference is of concern, as is the 68% increase in the African American rate between 1997 and 1998. Small numbers are a contributing factor, for instance in 1997 there were 9 African American infant deaths and in 1998 there were 14. The causes of the 14 deaths were: extreme prematurity (6), congenital anomalies (3), cardiorespiratory failure (3), and pneumonia (2).

More than half (9) of the 14 African American infants who died were of low birth weight (born weighing less than 2,500 grams), 8 of whom were born weighing less than 1,000 grams. The relationship between low birth weight and infant mortality is discussed later in the low birth weight section. Low birth weight has been rising in Rhode Island and the rate among African Americans is nearly twice the rate for Whites.

Nine of the 14 deaths occurred neonatally. Maternal and infant characteristics were examined for both the

African American and White infant deaths. There do not appear to be any significant differences, although a higher proportion of the African American mothers smoked during pregnancy than the White mothers.

Figure 18



Infants born to mothers residing in the five core cities had a higher rate of mortality compared with those born in the rest of the state. In 1998, they represented half of the total number (88) of infants who died that year, resulting in a rate of 8.7 deaths per 1,000 live births compared with the rate of 6.1 for the rest of the state.

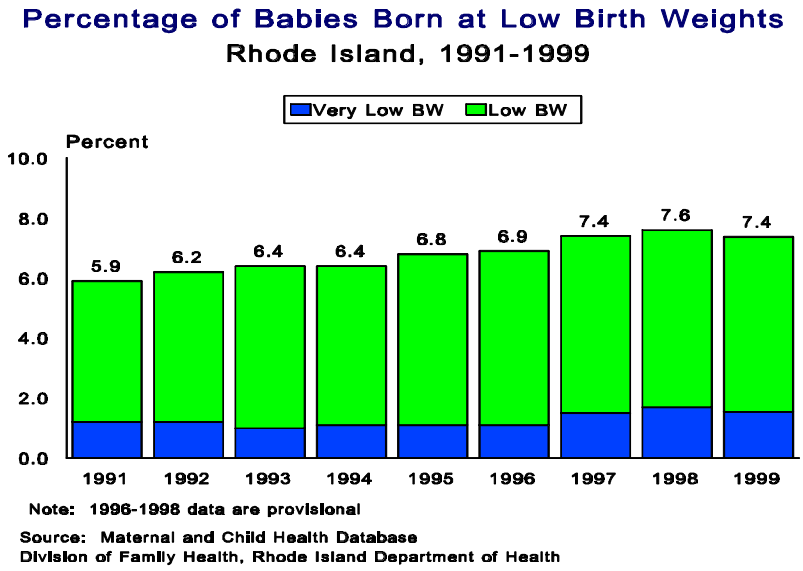
The recent improvements in infant mortality have occurred even though the low birth weight rate appears to have risen. In Rhode Island, during 1994-1998, low birth weight was associated with 70.4% of the infant deaths. Although very low birth weight infants (less than 1,500 grams) account for only one percent of all births in Rhode Island, they comprise more than half (56.4%) of all infant deaths in the state. Live births under 500 grams comprise nearly one-third (29.1%) of all infant deaths. The proportion of infant deaths that were among low birth weight infants has been rising. In 1994, 61.8% of infant deaths were among low birth weight infants and by 1998, this figure rose to 88.5%. Similarly, very low birth weight infants comprised 50% of the infant deaths in 1994, and by 1998, they comprised 74.7% of infant deaths.

The degree to which twin and triplet births have contributed to infant mortality has varied over the years. In 1992, 12 (11.2%) of the 107 resident infant deaths were twins (there were no triplet deaths) compared with 26 (29.5%) of the 88 resident infant deaths in 1998. It is interesting to note that during the years when Rhode Island experienced its lowest infant mortality, 1994,1996 and 1999, twin and triplet deaths accounted for 8.8%, 6.1% and 8.8% of the infant deaths for those respective years. Specifically, twin/triplets accounted for 6 of the 68 infant deaths in 1994; 4 of the 66 infant deaths in 1996; and 6 of the 68 deaths in 1999. The impact of multiple births on the low birth weight rate is discussed in the following section on low birth weight.

Low Birth Weight

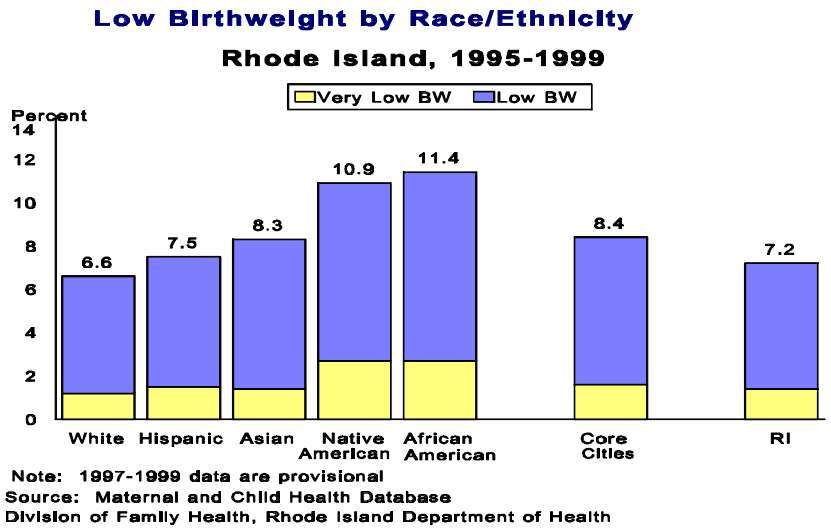
During the 1990s, Rhode Island saw a rise in the percentage of babies born at low birth weight (less than 2,500 grams or 5.5 lbs). In 1991, babies born at low birth weights accounted for 5.9% of all births and provisional data indicate that in 1999, 7.4% of babies were born at low birth weight (Figure 19). Between 1996 and 1999, the percentage of babies born weighing between 1,500 and 2,499 grams remained stable at 5.9%. However, the percentage of babies born at very low birth weight (less than 1,500 grams or 3.3 lbs) rose from 1.1% to 1.5%.

Figure 19



There is much disparity within the low birth weight rates among different racial and ethnic groups (Figure 20). During the 1995-1999 period, 7.2% of all babies born to Rhode Islanders were born at low birth weights. The low birth weight rate among African Americans was the highest at 11.4% and was nearly twice the rate for Whites (6.6%). Low birth weight rates were also higher among Native Americans (10.9%), Asians (8.3%) and those of Hispanic/Latino ethnicity (7.5%). Differences in low birth weight were also seen among those residing in the core cities and the rest of the state; 8.4% of births to those in core cities were born at low birth weights compared with 6.5% of births to those residing in the rest of the state.

Figure 20



In Rhode Island, 1.4% of babies were born at very low birth weights (<1500 grams) during 1995-1999. African Americans and Native Americans were more than twice as likely to deliver very low birth weight infants than Whites, where 2.7% of both African American and Native American babies were of very low birth weights compared with 1.2% of White babies.

Multiple Gestation Births

Babies born as multiple births (i.e., twins, triplets, and higher order births) are at a higher risk for low birth weight (less than 2,500 grams), prematurity (less than 37 weeks gestation) and infant death (deaths occurring within 364 days of birth) compared with singleton births. Over the past ten years, Rhode Island has experienced an increase in the number and rate of multiple births, a trend that mirrors the rest of the nation.

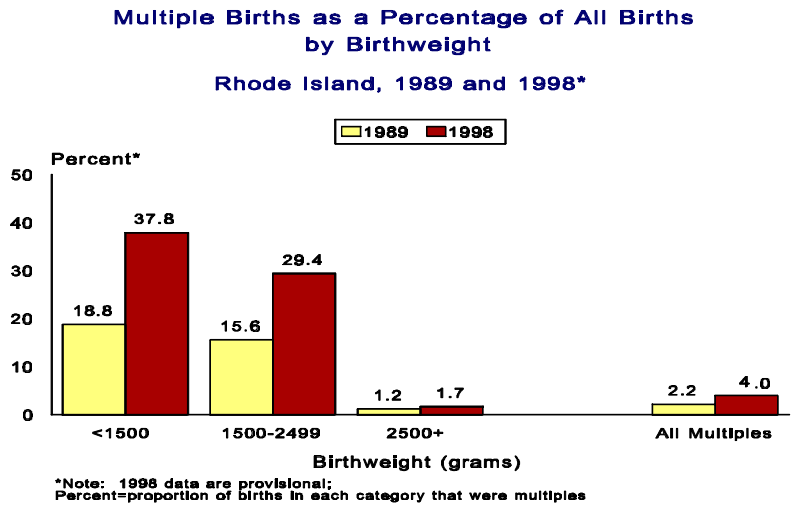
In 1989, Rhode Island passed legislation requiring public and private insurers to provide coverage for medically necessary infertility diagnosis and treatments, including fertility drug therapies, *in vitro* fertilizations, and other assisted reproductive technologies. Since then, Rhode Island has seen changes in its birth outcomes including a dramatic increase in multiple births and an increase in the percentage of babies born at low birth weight.

Between 1989 and 1998, the number of multiple births in Rhode Island rose from 327 births to 500 births, a 53% increase. The rate of multiple births increased more sharply from 22.1 per 1,000 live births to 39.7, an increase of 80%. During this same ten-year period, the number of singleton births declined from 14,441 to 12,098, a 16% decrease. Specifically, in 1989, 320 twin babies were born; by 1998, this figure had grown to 463, a 38% increase. Triplets also rose during this period, though more dramatically. In 1989, there were seven triplet births and by 1998, there were 37, a 429% increase. Provisional data indicate there were 54 in 1999.

Low Birthweight: In Rhode Island, between 1989 and 1998, the percentage of all babies born at low birthweights rose from 6.2% to 7.6%. This increase has occurred while other perinatal indicators have been improving, e.g., a decline in the rates of teen births, maternal tobacco use and infant mortality.

In 1989, multiple births represented 2.2% of all births, 16.3% of low birth weight births, and 18.8% of all very low birth weight (less than 1,500 grams) births. Comparatively, in 1998, multiple births represented 4.0% of all births, 31.3% of low birth weight births and 37.8% of the very low birth weight births. (Figure 21)

Figure 21



The percentage of multiple births that were low birth weight and very low birth weight has risen during 1989-1998. In 1989, 45.3% of multiple births were low birth weight and 10.4% were very low birth weight compared with 59.8% low birth weight and 16.2% very low birth weight in 1998. There was virtually no change in the proportion of singleton births that were low birth weight or very low birth weight.

Prematurity: During the 1989-1998 period, the percentage of babies born prematurely, i.e., prior to 37 weeks gestation, increased from 5.9% to 7.1%. However, the percentage of multiple births born prematurely rose from 22% to 42%. In 1989, multiple births accounted for 8% of all premature births and in 1998, they accounted for 24% of all premature births.

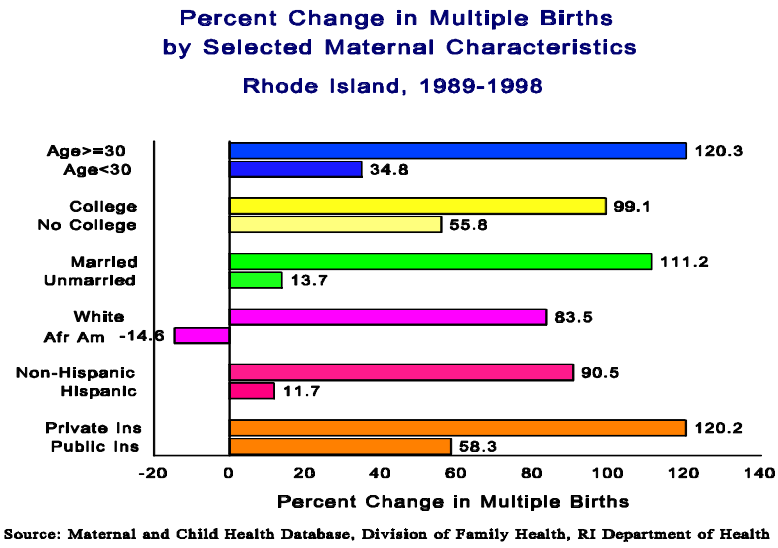
Infant Deaths: Infant mortality has declined in Rhode Island over the last decade as it has in the rest of the country. To account for the relatively small numbers of infant deaths in the state each year and the year-to-year fluctuations in the infant mortality rate, data have been analyzed for two five-year periods, 1989-1993 and 1994-1998.

During the period 1989-1993, the infant mortality rate in Rhode Island was 8.2 compared with 6.2 during the 1994-1998 period, a 24.4% decrease. Although the multiple infant mortality rate has decreased by 28.3%, from 46.7 to 33.5, a growing proportion of infant deaths are among multiple births. Of the 602 infant deaths which occurred during 1989-1993, 82 (13.6%) were among multiple births. During 1994-1998, 66 (16.5%) of the 399 infant deaths were among multiple births.

Maternal Characteristics: Figure 22 compares the changes in rates of multiple births between 1989 and 1998,

by selected maternal characteristics, including age, marital status, education, race/ethnicity, and insurance. The multiple birth rate approximately doubled among women who were aged 30 or above, college-educated, married, White, or privately insured.

Figure 22



National Trends: In 1998, Rhode Island's multiple birth rate (twins, triplets and higher order births per 1,000 live births) of 39.7 was 32% higher than that of the United States' rate of 30.0. Both the twin and triplet birth rates were higher in Rhode Island than in the United States. Specifically, the twin birth rate (twins per 1,000 live births) in Rhode Island was 36.8 compared with 28.1 in the United States. The triplet birth rate (triplets per 100,000 live births) in Rhode Island was 293.7 compared with 193.5 for the country. During the 1989-1998 period, Rhode Island's triplet rate rose 520% compared with 180% for the country.

Some of the increase in multiple births can be attributed to an increase in the use of fertility drugs and assisted reproductive technologies. The National Center for Health Statistics reports that about one-third of the increase in triplet births is due to the fact that more older women, who are more likely to have multiple births, are giving birth. About two-thirds of the increase is due to the increasing use of fertility treatments, independent of the mother's age.

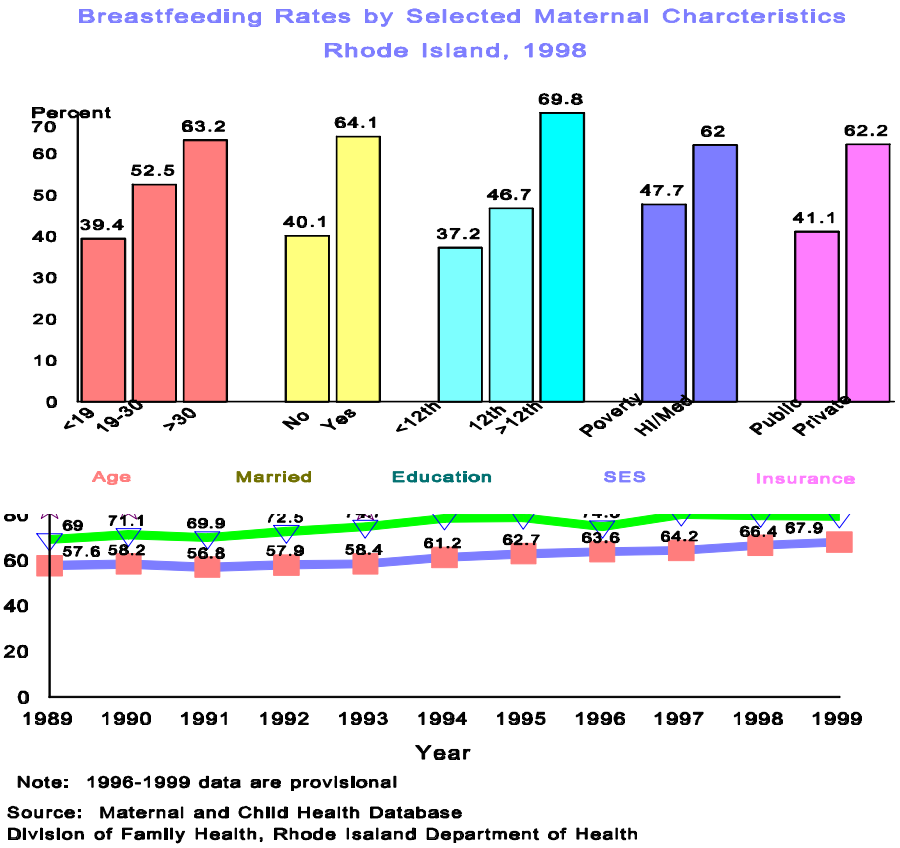
Low Birth Weight Babies Born at Regional Perinatal Center

A high proportion of babies born at low birth weights is delivered at the regional perinatal center indicating that high risk pregnancies are being identified early and are being referred to the perinatal center. As previously described, the number of babies born at low birth weights to Rhode Islanders has been increasing. Over the past ten years, the proportion of low birth weight babies born at the regional perinatal center has also increased. In 1989, 69% of low birth weight babies and 82.9% of very low birth weight babies were born at the regional perinatal center. By 1999, 697 (79.1%) of the 881 babies born at low birth weights, and 171 (92.9%) of the 184 babies born at very low birth weights, were born at the regional perinatal center (Figure23).

The majority of the births among Rhode Island residents occur at the regional perinatal center and this

proportion has also increased over the past ten years (Figure 23). In 1989, 57.6% of births were delivered at the regional perinatal center, and by 1999, this proportion rose to 67.9%.

Figure 23



PRIORITY: PROVIDE EDUCATION, SUPPORT AND ENVIRONMENTAL RISK REDUCTION TO FAMILIES

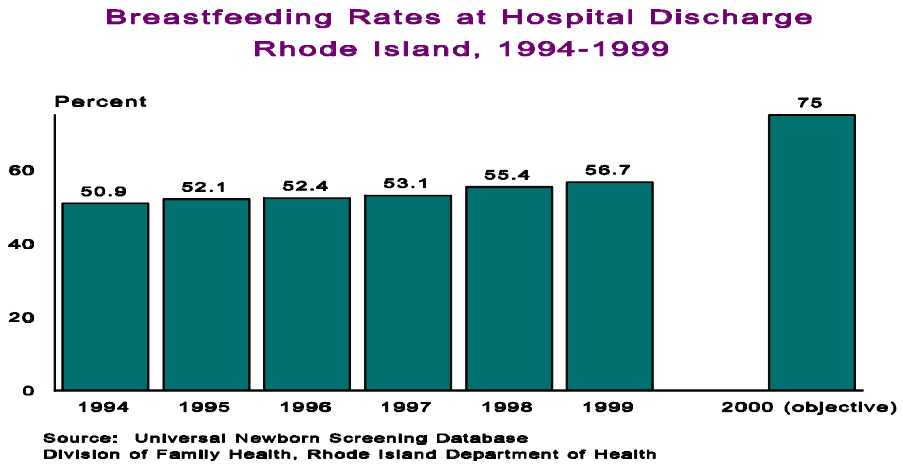
Breastfeeding

According to Universal Newborn Developmental Risk Screening (Level I) data, the breastfeeding rate (at hospital discharge) in Rhode Island is slowly rising. In 1994, 50.9% of women were breastfeeding at hospital discharge and by 1999, this figure rose to 56.7% (Figure24).

Figure 24

Figure 25 shows that women are more likely to breastfeed if they are older, married, have more than a high school education, are of a high or medium socioeconomic status, and have private insurance. For example, in 1998, 63% of women aged thirty-one or older were breastfeeding compared with 39% of mothers aged 18 or under; and 52% of women aged 19-30. Similarly, 70% of those women who had more than a high school education were breastfeeding compared with 37% of women who had less than a high school education.

Figure 25



Breastfeeding rates also varied among those with private health insurance and public health insurance. Of those with private insurance, 62% were breastfeeding compared with 41% of those enrolled in public insurance programs.

Breastfeeding rates also differed among women of different racial/ethnic groups. Whites and those of Hispanic/Latino ethnicity were more likely to breastfeed than African Americans or Asians. In 1998, 57% of Whites and 54% of Hispanic/Latinos were breastfeeding, compared with 43% of African Americans and 45% of Asians. Between 1995 and 1998, increases in breastfeeding rates were seen among all of these populations. However, the rate

of increase varied; Asians and African Americans had a higher rate of increase (31% and 27%, respectively), during this period than Whites and Hispanics (5% and 8%, respectively).

B. Children

PRIORITY: ASSURE THE HEALTH, SAFETY AND OPTIMAL DEVELOPMENT OF CHILDREN IN CHILD CARE

Child Care (Note: The source for the information presented below is from the *1999 Rhode Island KIDS COUNT Fact Book*, Rhode Island KIDS COUNT, Providence, RI)

Infant and Preschool Child Care

Child care has become a fundamental need for Rhode Island families over the past two decades. In Rhode Island in 1997, 67% of mothers with children under the age of six were in the labor force. More than 45,000 Rhode Island infants and preschool children are in need of some form of child care because their mother is in the labor force. The availability of licensed and certified (regulated) child care for children under age six is limited, however. Estimates show that in Rhode Island during 1999, 26,143 children under six years of age were in need of regulated child care, yet there were only 20,383 regulated child care slots. In other words, for every 100 children in need of licensed/certified child care, only 78 slots are available. This is a slight improvement since 1998, when there were only 70 slots available.

The supply of regulated child care is particularly limited in low-income communities and rural areas, for infants and children under the age of three, for children with disabilities special health care needs, and for parents with unconventional or shifting work hours. For example, for every 100 children in need, Central Falls only has 26 child care sots available; Pawtucket has 50 slots; Woonsocket has 51; Newport has 61. Rural communities such as Burrillville and Exeter have even fewer slots, with 26 and 30 slots, respectively.

Insufficient capacity in Rhode Island is also affecting children aged 3 and 4 eligible for Head Start. In 1999, of the estimated 5,293 children eligible for Head Start, only 2,491 (47%) were enrolled. The core cities had only enough capacity to enroll 1,436 (37%) of the 3,846 3 and 4 year olds eligible for Head Start.

It should be noted that Head Start now offers a program for pregnant women and their infants and children up to the age of three. In Rhode Island, 291 families receive services from Head Start.

Under Starting Right, Rhode Island's child care law, resources have been appropriated to expand Head Start and to create comprehensive child care programs in underserved communities. Comprehensive child care programs will provide a developmentally-appropriate education program and link with other community programs to provide health, nutrition, mental health, and social services; services for children with special health care needs; and assistance with transition to kindergarten.

School-Age Child Care

The supply of licensed child care for children ages 5-12 has increased from 5,750 slots in 1995 to 12,267 slots

in 1999, a 113% increase. Of the slots available in 1999, 7,680 were school-based and 4,587 were community-based. However, before and after-school care continues to be in short supply, particularly after-school programs for children aged 11-15. In Rhode Island, as of December 1999, there were 1,349 licensed slots for youth aged 11-15.

Under Starting Right, child care subsidies are an entitlement for all families with incomes less than 225% of poverty for after school programs. These subsidies can be used for after-school programs for children up to age 16. As of December 1999, of the 11,915 children receiving child care subsidies, 3,869 (32.5%) children were aged 6-16 and using subsidies for school-age child care programs.

Data from the 1998-1999 Rhode Island *School Accountability for Learning and Teaching (SALT) Survey* indicate that in 1999, one in five (21%) Rhode Island middle school children in grades 6, 7 and 8 were home after school without adult supervision for more than three hours on at least three days a week. An additional 4% are home without adult supervision for more than three hours on one or two days a week. Young people left on their own in the afternoon or evening hours are at significantly higher risk for becoming involved in substance abuse, sexual activity, crime, and violence than their peers who are engaged in constructive and supervised activities.

SALT Survey data have also shown that Rhode Island middle school students from low-income families are less likely than students from high-income families to participate in extracurricular activities and programs. In 1999, 67% of low-income middle school children belonged to and regularly attended at least one extracurricular activity compared with 82% of higher-income families.

Child Care Provider Training

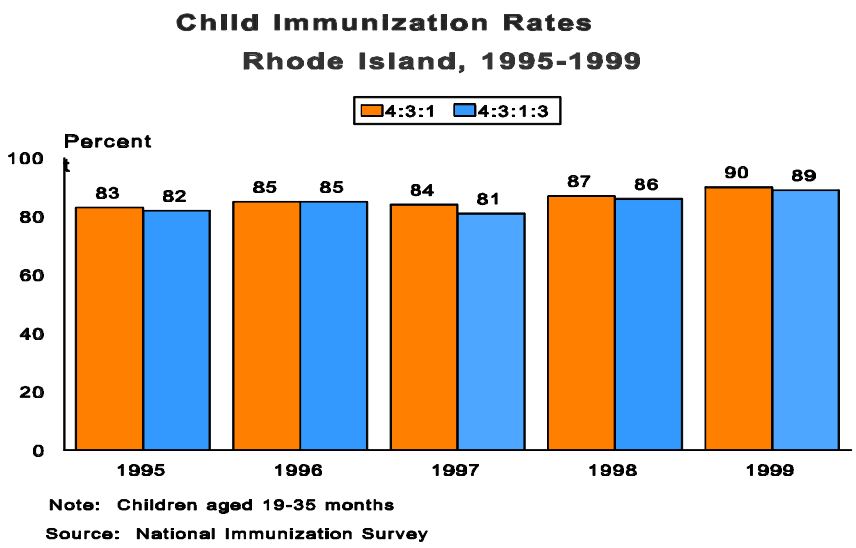
In order to ascertain the current status and future needs of child care provider training in Rhode Island, a survey was developed as part of the Starting Right implementation project. This was an initial attempt to ascertain the training needs of child care providers as well as availability of training. The survey was distributed at the Rhode Island Early Childhood Conference in April 1999, to approximately 800 child care providers. The return rate was 38%. Of those who responded, 40% were teachers; 31% were teacher□s aids; 12% were head teachers; 10% were directors/administrators; and 5% were family child care providers. The majority reported they planned to stay in the field five years or more, where 43% planned to stay in day care for at least five years and 36% planned to stay in day care for 10 or more years. When asked what would keep them in the child care field, 40% ranked better salaries first; and 12% reported health benefits first. The areas in which the respondents would like to receive training and the percent who report interest were: curriculum, 32%; behavioral/mental health, 30%; infant/toddler, 11%; administration, 9%; special needs, 5%; health and safety, 4%; multicultural issues, 4%; and parent communication, 4%.

Immunization

Immunization rates among children aged 19-35 months have been rising in both Rhode Island and the nation. According to the National Immunization Survey, during the five year period, 1995-1999, the percentage of children aged 19-35 months with complete vaccination coverage for the 4:3:1 series rose from 83% to 90% (Figure 26). The most recent survey conducted in 1998-1999, ranked Rhode Island first in the country for highest rate of vaccination coverage among children aged 19-35 months with the 4:3:1 series, where 90.4% of children were vaccinated. When the haemophilus influenzae type b vaccine is included, the 4:3:1:3 series, the rate drops to 89.1%, although the best in the country for the series.

Vaccination rates vary by race/ethnicity. National Immunization Survey data have shown differences in rates among those of Hispanic/Latino ethnicity and Whites, where in Rhode Island during 1998-1999, 82.9% of Hispanic/Latino children had completed the 4:3:1 series compared with 93.1% of White, non-Hispanic children.

Figure 26



Immunization levels in Rhode Island for children entering kindergarten are also excellent. Statewide results for the 1999-2000 year were reported on 12,392 kindergarten children with 94% of these children having the 4:3:2 series at school entry.

A retrospective school survey conducted to validate the school entry survey show that 78% of children entering kindergarten had completed the 4:3:1 series by the time they were 24 months of age. However, differences exist in immunization levels among those living in the five core cities and the rest of the state, where 71% were vaccinated by 24 months compared with 81% of children in the rest of the state.

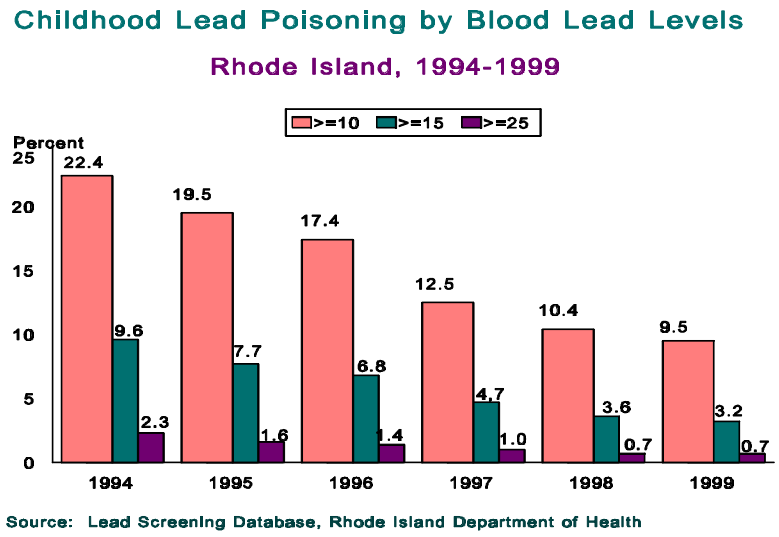
Children in day care and Head Start centers also had high rates of vaccination completion. In 1999-2000, 88.5% of children in day care centers and 89.9% of children in Head Start centers had completed the 3+:3:1 (and 1+doses of Hib, $\geq$ first birthday) series.

PRIORITY: PROVIDE EDUCATION, SUPPORT AND ENVIRONMENTAL RISK REDUCTION TO FAMILIES

Lead Poisoning

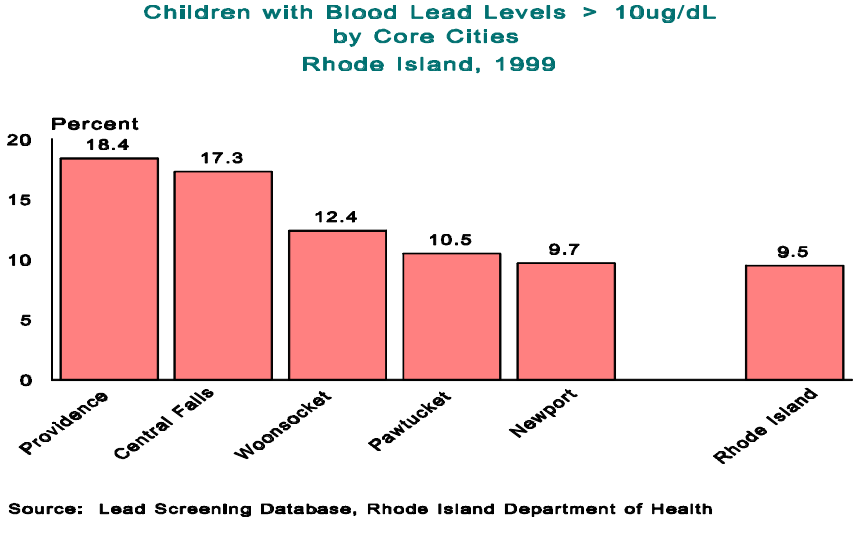
In Rhode Island, the proportion of children with elevated lead levels has been decreasing. Between 1995 and 1999, the percentage of children screened for lead poisoning who had lead levels at or above 10ug/dL, decreased from 19.5% to 9.5% (Figure 27). Similar changes were also seen in the proportion of children with lead levels at or above 15ug/dL and 25ug/dL.

Figure 27



There were, however, differences in the proportion of children with high lead levels and town of residence. Children residing in Rhode Island's core cities had higher rates of lead poisoning than the statewide average (Figures 28 and 29). Specifically, children living in Providence and Central Falls had rates that were nearly twice that of the state.

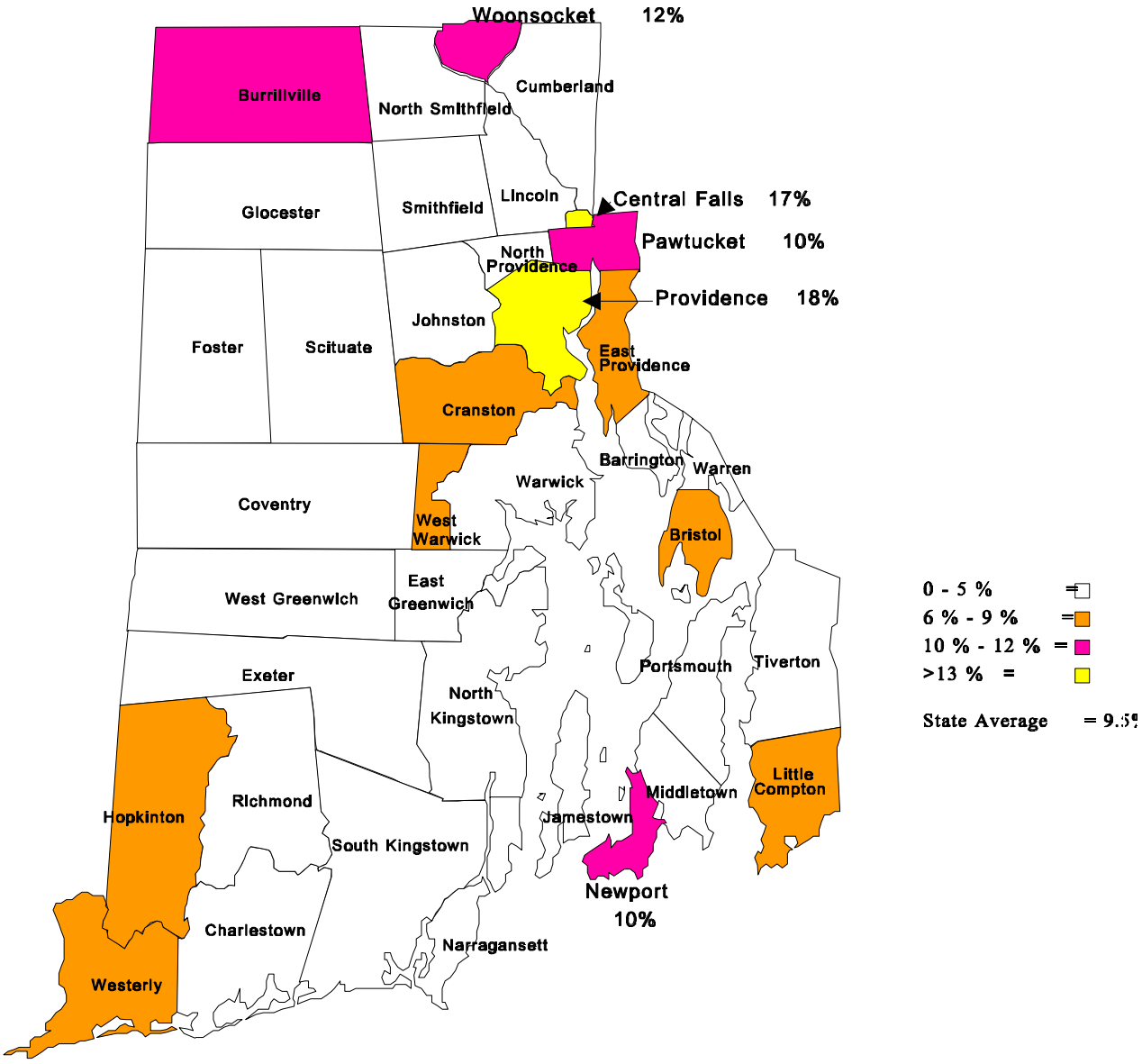
Figure 28



Lead poisoning rates also varied among children of different racial/ethnic groups. Figure 30 shows that the greatest disparities were among Southeast Asians and African American whose rates were three times that of Whites, 24.3% and 24.0% compared with 7.6%. Native Americans and those of Hispanic/ Latino ethnicity had rates that were more than twice the rate of Whites.

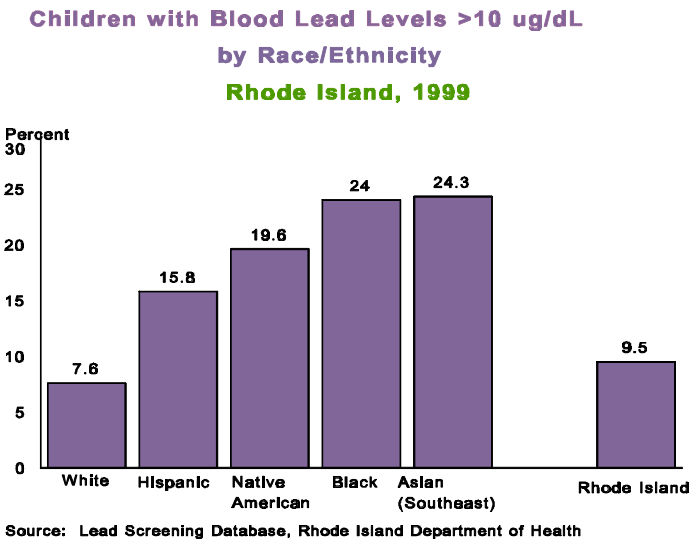
Figure 29

Proportion of Children with Blood Lead Levels ≥10 ug/dL
Rhode Island, 1999



SOURCE: Rhode Island Childhood Lead Poisoning Prevention Program

Figure 30



Door-to-Door Survey

During 1999, in order to assess individual, household and health system factors related to lead screening penetration, a survey was conducted among families residing in four of Rhode Island's five core cities: Providence, Pawtucket, Central Falls and Woonsocket. Door to door interviews were completed among 500 families. Although the survey indicated that access to health care for children aged less than six was high in all four communities, lead screening rates ranged from 63% to 83%. The amount of time families were living at their current address had a statistically significant association with absence of a regular source of care, screening compliance, and health insurance. Lack of awareness about lead poisoning as a problem was the behavioral variable most consistently associated with partial household screening (one or more children in the household not tested) in these communities.

Despite high insurance coverage, families moving across or within poverty areas are more likely to experience disruptions in the continuity of their children's care, including lead screening. In some communities, this association was present two years after address changes. Recent migration to the United States was not associated with low screening levels.

Survey Data: Children in Day Care Centers and Kindergartens

During 1998-1999 and 1999-2000, the Rhode Island School Immunization Survey conducted among 262 day care centers and 239 kindergartens, included a question regarding lead screening. Results from the 1999-2000 survey indicate that of the 10,808 children in the day care centers which responded to the question, 2,003 (18.5%) had no evidence of lead screening. A slightly lower proportion (18.2%) of children residing in the five core cities had no evidence of lead screening compared with children residing in the rest of the state (18.7%). The results from this survey show an improvement compared with the survey conducted during 1998-1999, when 27.8% of children in day care centers had no evidence of lead screening.

Of the 12,025 children in kindergartens which responded, 3,351 (27.9%) kindergartners had no evidence of

lead screening. Kindergarteners residing in the core cities were less likely to have a lead screening (35.6%) than those children residing in the rest of the state (24.1%). These results are an improvement compared with the 1998-1999 survey, when 44.7% of kindergartners had no evidence of lead screening. An improvement was especially seen among children residing in core cities, where more than half, 57.3%, had no evidence of lead screening.

Hospitalizations Among Children

During July 1997 through June 1998, 6,837 Rhode Island children under age 18 were hospitalized. Diagnoses related to the respiratory system (1,504 or 22%) and those related to poisons and injuries (747 or 11%) accounted for the most hospitalizations. The most frequent diagnoses were acute respiratory infections (560 or 8.2%); other infections (435 or 6.4%); and asthma (424 or 6.2%). Of the total hospitalizations, more than half (3,500 or 51.2%) were among children aged less than five; 1,513 or 22.1% were among children aged 5-12; and 1,824 or 26.7% were among teens aged 13-17.

Hospitalizations for asthma are discussed below and hospitalizations for injuries are discussed on page110.

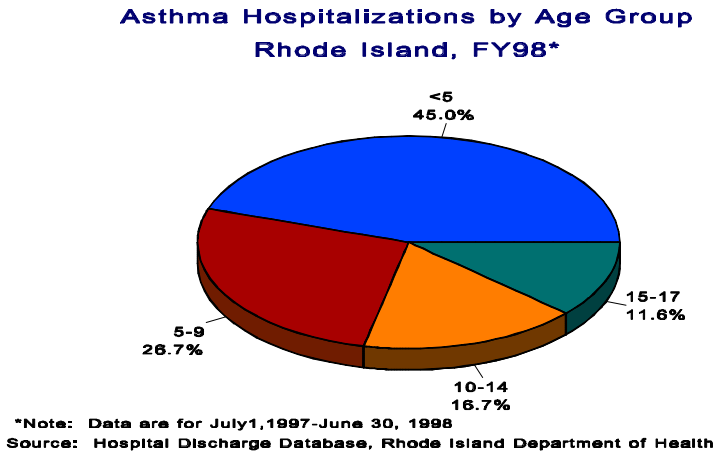
Asthma

Hospitalizations

As stated in the *2000 Rhode Island KIDS COUNT Fact Book*: asthma is a chronic breathing disorder and one of the most common chronic health problems among children. Most cases of childhood asthma can be managed by the child d primary care physician. Accessible and timely medical care can prevent severe episodes of asthma. Hospitalization for asthma may indicate that the child has not had adequate outpatient management for the disease.

In Rhode Island during July 1997 through June 1998, 424 children under the age of 18 were hospitalized for asthma. Children aged less than five represented the highest proportion of these hospitalizations at 45.0%; children aged 5-9 accounted for 26.7%; children aged 10-14 accounted for 16.7%; and the fewest hospitalizations occurred among older teens aged 15-17, accounting for 11.6% (Figure 31). The hospitalization rate (number of hospitalizations per 1,000 children) was also highest among children aged less than five, at 3.1. Children aged five and older had hospitalization rates on average of 1.3.

Figure 31



More than half , 239 (56.4%), of the

424 hospitalizations for asthma occurred among children residing in the core cities. Hospitalization rates were highest among children residing in Providence and Woonsocket; both communities had rates of 3.9, more than twice the statewide rate of 1.9.

Althought the majority of hospitalizations were among Whites (57%), 15% were among those of Hispanic/Latino ethnicity; 14% were among African Americans; and 4% were among Asians. The hospitalization rate for African Americans (3.4) was the highest compared with other racial/ethnic groups and three times the White rate (1.1). Children of Hispanic/Latino ethnicity had a hospitalization rate of 2.7, nearly 2.5 times the rates for Whites. Asian children had a slightly lower rate (1.8) than the statewide rate.

Rhode Island Health Interview Survey Data

The 1996 Rhode Island Health Interview Survey contains information representing 6,583 Rhode Islanders, of whom 470 (7.1%) had asthma. Of the 470 with asthma, 155 were children under the age of 18. A total of 1900 children under the age of 18 lived in the households contacted, and therefore, 8.2% of these children had asthma. Children under six years of age accounted for 37 (23.9%) of the 155 children with asthma and children aged 6-17 accounted for the remaining 118 (76.1%). A higher proportion of school-age children had asthma compared with infants or preschool-age children. Of the 629 children aged less than six in the survey, 5.9% (weighted percentage) had asthma; and of the 1,271 children aged 6-17, 10.1% (weighted percentage) had asthma.

PRIORITY: IMPROVE THE NUTRITIONAL STATUS OF CHILDREN

Children in the WIC Program

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a preventive program providing nutritious food, nutrition education and improved access to health care. WIC serves pregnant women, infants and children under the age of five. Household income must be below 185% of the federal poverty level. Participants must have a specified health or nutritional risk (e.g., abnormal pregnancy weight gain, iron deficiency anemia, etc.). The WIC Farmer's Market Nutrition Program provides coupons to WIC participants for the purchase of fresh produce at local farmers' markets. In 1999, nine farmers' markets provided produce to 12,000 WIC recipients.

WIC also promotes breastfeeding. Breastfeeding mothers qualify for a special food package and program eligibility is extended for one year. WIC has implemented breastfeeding support programs including the TLC (Lactation Consultant) hospital-based perinatal breastfeeding support program to assist low income breastfeeding women prior to hospital discharge and the Mother-to-Mother Peer Counseling Program which provides culturally competent breastfeeding support and promotion among WIC participants.

As of December 1999, it is estimated that 84% of eligible pregnant and postpartum women, 100% of eligible infants, and 66% of eligible children were served by the Rhode Island WIC Program. Overall, 76% of eligible women, infants and children were served by the WIC Program.

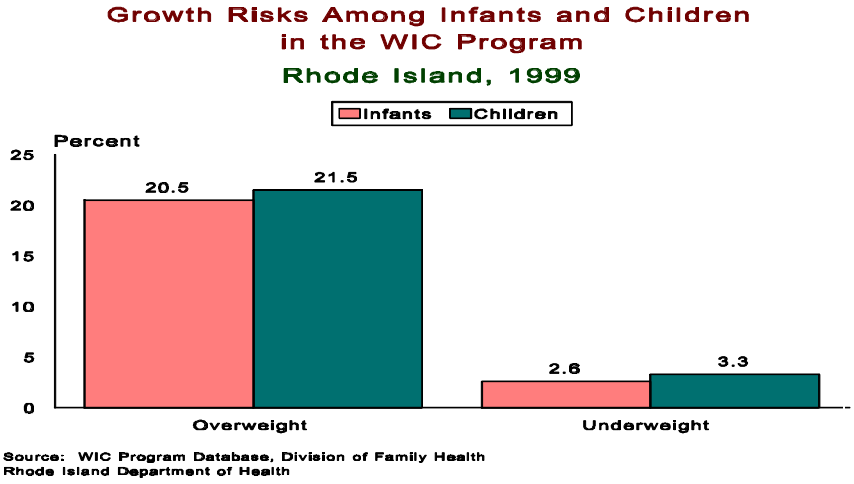
Childhood obesity continues to be a significant health risk among children in Rhode Island. Data from the

Rhode Island WIC Program indicate that in 1999, 1,157 (20.5%) of the 5,635 infants and 2,982 (21.5%) of the13,870 children enrolled in the WIC Program were overweight (Figure 32). For infants, overweight is defined as a stature for height that is greater than or equal to the 90th percentile; for children, it is defined as a stature for height that is greater than or equal to the 95th percentile. Infant and child obesity has been the most frequently identified growth risk among children in WIC. Feeding habits, parenting skills, poor nutrition and lack of exercise contribute to this problem.

Fewer infants and children were identified as being underweight (low weight for stature); 146 (2.6%) of the infants were less than or equal to the 25th percentile for stature for weight and 452 (3.3%) of the children were less than or equal to the 10th percentile

for stature for weight.

Figure 32



F

ood Security

The Division of Family Health has gathered data on food security through two mechanisms, a recent Food Security/Hunger Survey and the WIC Program's Annual Participant Survey. Data from these surveys, as described below, indicate that a large portion of low income households are food insecure.

Food Security Survey

During spring 1999, the Rhode Island Department of Health first conducted a Food Security Survey among 410 households using the 18-item food security module developed by the USDA. The Rhode Island Food Security Survey included additional sociodemographic questions which included: respondent's age, marital status, education level, race/ ethnicity, employment status, household size, and income. Households in Rhode Island's 41 poverty census

tracts were randomly selected utilizing a random digit dial telephone list. Only the person responsible for purchasing food for the household was interviewed and for this analysis will be referred to as the head of the household.

The survey was repeated during spring 2000 among 400 households, with 397 complete surveys obtained. Preliminary results from the 2000 survey indicate that of the 397 households surveyed, 98 (24.7%) were determined to be food insecure. Of these 98 food insecure households, 41 (10.3% of the total sample) were food insecure with hunger or severe hunger as defined by the USDA in the Household Food Security in the United States reports (see Figure 33).

Figure 33

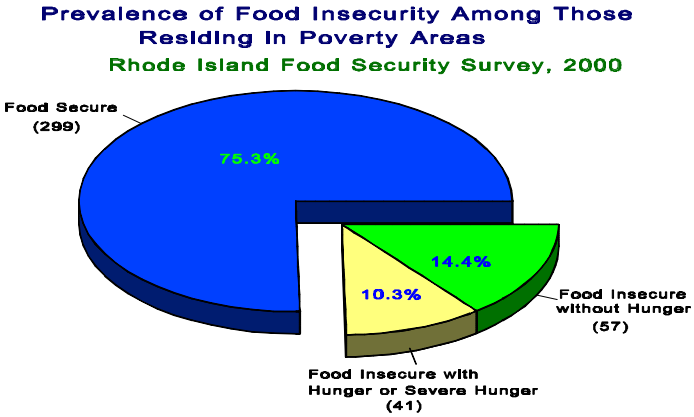


Figure 34 illustrates differences in the prevalence of food insecurity among households by education level, ethnicity, children under age 6, and marital status. The greater the education level, the less likely the household was food insecure (FI):

- of the 100 households where the head had less than a high school education, 38 (38.0%) were FI
- of the 157 households where the head had graduated from high school, 39 (24.8%) were FI; and
- of the 129 households where the head had some college education, 19 (14.7%) were FI.

Although there were differences in food security status among racial/ethnic groups, there were only significant differences between those of Hispanic/Latino ethnicity and those who were not. Of the 68 household heads who identified themselves as Hispanic, 28 (41.2%) were food insecure, compared with 66 (21.6%) of the 306 household heas who stated they were not of Hispanic ethnicity ($p < .001$).

Households with children, especially those with children aged less than six, were more likely to be food insecure than households with no children. Of the 162 households with children, 51 (31.5%) were assessed to be food insecure compared with 20.1% of the households with no children. ($p < .01$) Of the 82 households with children aged less than six, 25 (39.0%) were food insecure compared with 21.1% of households with no children aged less than six. ($p < .001$)

There were also differences in food security among those who were married (includes living with a partner) and those who were single (includes widowed, divorced, and separated). Of the 210 household heads who were single,

64 (30.5%) were food insecure compared with 17.5% of those who were married. Those who were single and had children in the household were more likely to be food insecure than those who were married with children in the household; 41.2% of single headed households with children were food insecure compared with 23.3% of married couples with children. ($p < .0.05$)

Although age did not appear to be a significant risk factor for food insecurity, older respondents aged 65 or older were less likely to be food insecure than younger respondents. Of the 43 respondents aged 17-24, 32.6% were food insecure while 15.6% of the 96 respondents aged 65 and older were food insecure.

Figure 34

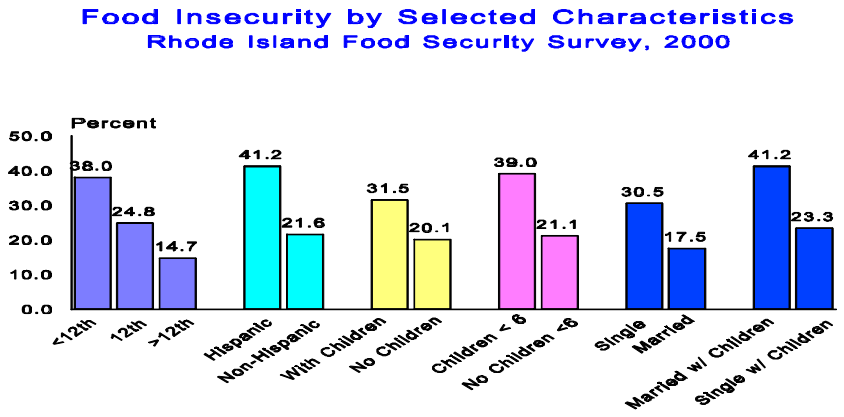


Figure 35 illustrates the differences in the prevalence of food insecurity among households by employment status, family size, and poverty level. Those households where no members were employed were more likely to be food insecure as those households where at least one member was employed at least parttime (20 hours per week or more). Of the 144 households where no one was employed, 45 (31.2%) were food insecure compared with 53 (21.1%) of the 251 households where at least one member was employed. ($p <.05$)

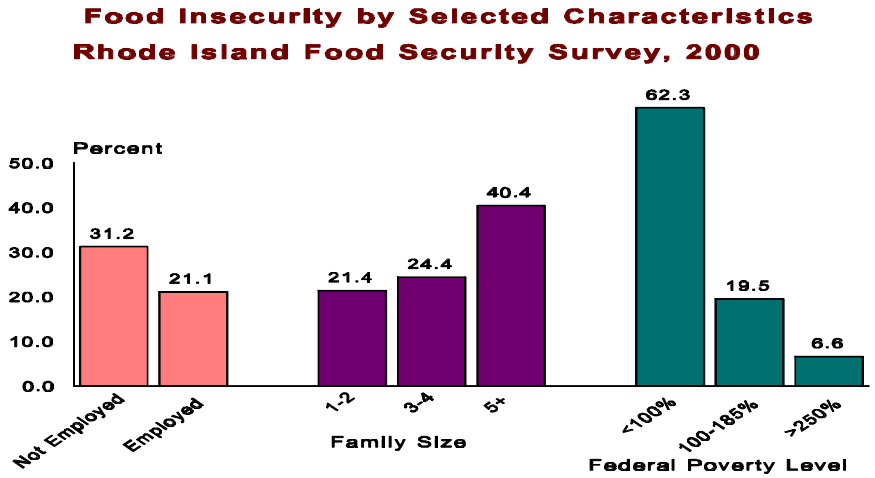
Larger households were nearly twice as likely to be food insecure compared to smaller households. Of the 52 households with 5 or more individuals, 40.4% were food insecure compared with 21.4% of households with 1-2 (n=224) and 24.4% of households with 3-4 individuals (n=119). ($p <.05$)

Households with annual incomes less than 100% of the Federal Poverty Level (FPL) were nearly 9 times more likely to be food insecure than households with incomes greater than 250% of the FPL. Of the 77 households with incomes less than 100% of the FPL, 48 (62.3%) were food insecure; whereas, 6.6% of the 137 households with incomes above 250% of the FPL, were food insecure. ($P<.001$). Of the 82 households with incomes between 185% and 250% of the FPL, 19.5% were food insecure.

Nearly one in ten (n=36) of the respondents had received food assistance from emergency food pantries or other programs. Households that received food assistance were three times as likely to be food insecure as households that did not receive assistance. Two-thirds or 66.7% of the households that received assistance were food insecure

compared with 20.1% of the 360 households that did not receive any assistance.

Figure 35



Rhode Island Women, Infants and Children (WIC) Program Participant Survey Data

Data from the Rhode Island WIC Program indicate that many low income families are struggling to provide adequate quantities and quality of food for their households. Participants in the WIC Program include pregnant and postpartum women, infants and children under the age of five who meet income eligibility criteria and have a nutritional risk. The WIC Program conducts an annual statewide survey that is completed by at least 1,000 participants and includes questions regarding how often they worry they will run out of money to buy food and how often they can afford to eat properly. The results have been very consistent over the past years (1996-1998) and show that about 70% of those surveyed worry they will run out of money to buy food where, 21% "often" worry and 49% "sometimes" worry. Only 50% of respondents indicated they could "often" afford to eat properly.

School Breakfast

In 1999, the Rhode Island General Assembly expanded the mandatory school breakfast law, originally passed in 1998, to include all elementary, middle and high schools in which 20% or more of the students are eligible for free or reduced price lunches. Currently, 229 (72.2%) of the 317 public schools in Rhode Island offer the School Breakfast Program. In 1999, of the 51,147 low-income students in Rhode Island, 45,306 (89%) attended schools with breakfast. Of the 34,757 low income students attending school in one of Rhode Island's five core cities, 34,129 (98%) attended schools with breakfast. Of the low-income students attending school in the remainder of the state, 68% attend schools with breakfast programs. The number of low-income students in schools that do not offer the School Breakfast Program has decreased 65%, from 16,905 in 1995 to 5,841 in 1999.

Oral Health

According to the 1996 Rhode Island Health Interview Survey, of the 574 respondents with children under age six who drink from a baby bottle, 286 (49.8%) stated their child fell asleep while drinking a bottle once in a while,

sometimes or most of the time. Of the 630 families with children under age six, 18 (2.9%) stated their child had lost a tooth due to unnatural causes other than injuries. Nearly one-third, 472 (29.5%), of the 1,599 respondents with children aged less than nineteen reported their child had more than one filling. Nearly half (47.0%) of the children aged 2-5 did not have a dental visit in the past 12 months, while 7.1% of children aged 6-17 did not. Approximately one-third (31.3%) of children aged 0-5 and one-quarter (26.2%) of children aged 6-17 did not have any dental care coverage.

PRIORITY: IMPROVE THE HEALTH, SAFETY AND OPTIMAL DEVELOPMENT OF ADOLESCENTS

Homeless Children

According to the *2000 Rhode Island KIDS COUNT Factbook*, during July 1998-June 1999 in Rhode Island, there were 994 children who received shelter from the emergency an domestic violence shelter system. Of these children, 919 were aged less than thirteen and 75 were aged 13-17. Homeless youth aged 13-17 are discussed in more detailed in the section on adolescents below. Nearly two-thirds of the families receiving shelter had incomes below $15,000 and one-third had no income at all. Reasons Rhode Island families needed shelter included: domestic violence (42%); housing problems (27%); no income (7); family separation (5%); natural disaster (2%); and unspecified reasons (18%).

Homelessness is of concern since homeless children have substantially higher leels of acute and chronic illness. They suffer twice as many ear infections, five times more diarrhea and stomach problems, and are four times more likely to have asthma than other children. Nearly 20% of homeless children lack a regular source of medical care. One-third of homeless children lack essential immunizations and one-third have never been screened for lead poisoning. Homeless children often suffer from emotional distress. Despite higher rates of mental health problems, less than one-third of homeless children receive treatment. Homelessness can also negatively affect a child's education. Homeless children are more likely to repeat a grade and to be suspended. Although homeless children are more likely to be learning disabled, they are less likely to receive special education services.

In 1999, the Better Homes Fund ranked Rhode Island 18th in the US for children at risk for homelessness based on a list of risk factors which include: percentage of families living in extreme poverty, foster care rates, children in households with worst case housing need, number of female-headed households, vacancy rate for affordable housing, number of school-age homeless children, and rate of decrease in welfare case loads.

Children and Domestic Violence

According to the *2000 Rhode Island KIDS COUNT Factbook*, police reports indicate that in Rhode Island during 1998, children were present during 2,573 (39%) of the 6,541 reported domestic violence incidents. An additional 87 incidents were reported to state police, during which 33 children were present. National surveys of mothers indicate that 87% of children have witnessed the abuse in homes where there is domestic violence. Children who experience

adult domestic violence in their homes suffer trauma even if they, themselves, are not physically harmed. Exposure to domestic violence can limit children's cognitive development and their ability to form close attachments. Children who experience violence over a period of time are more likely to have serious emotional and behavioral problems, including violent behavior. Children in homes where a parent is abusive to a spouse are at increased risk for child abuse.

In Rhode Island, there are six shelter and advocacy programs that offer services to children who witness domestic violence. Services include group therapy, individual counseling, expressive arts therapy, and child care. In 1999, the six domestic violence agencies provided services to 1,335 Rhode Island children, 387 (29%) of whom spent time in a domestic violence shelter.

Child Abuse and Neglect

The Rhode Island Department of Children, Youth and Families (DCYF) has reported that in 1999, there were 2,623 indicated cases of child abuse and/or neglect. Betweem 1994 and 1998 the number of cases of child abuse and/or neglect declined from 2,732 to 2,459, a 10% decrease. However, in 1999, the number of cases rose 6.7%. Cases can involve more than one child and in 1999, there were 3,485 children determined by DCYF to be victims of child abuse and/or neglect. Of these children, 236 (6.8%) were infants under the age of one; 29%% were aged 1-5; 37% aged 6-11; and 27% aged 12-18. During the period July 1998 and June 1999, 24 children were hospitalized with the diagnosis of child abuse and neglect. DCYF has determined that between 1990 and 1999, 40 children died as a result of injuries due to abuse by a parent or caretaker.

As reported in the *2000 Rhode Island KIDS COUNT Factbook*, child abuse and neglect happens to children of all races, in all kinds of communities, in all economic classes. However, national data indicate that poor families and families of color are more likely to be identified by the child welfare system and more likely to have their children removed and placed in foster care. The rate of cases of child abuse/neglect per 1,000 children in Rhode Island during 1999 was 9.3. The rate among children residing in the core cities was 14.3, twice the rate for the remainder of the state (6.7).

Child Injuries

As discussed earlier, during July 1997 and June 1998, there were 6,837 hospitalizations among Rhode Island children aged less than eighteen and of these, 747 (10.9%) were related to poisons and injuries. Of these hospitalizations, falls were the most frequent cause accounting for 200 or 27%, followed by other intentional causes (166 or 22%); motor vehicle accidents (136 or 18%); other vehicle-related accidents (56 or 7%); self-inflicted injuries (40 or 5%); and poisonings (34 or 5%).

According to the national 1997 Behavioral Risk Factor Surveillance System (BRFSS) data, 95.8% of the 113 Rhode Islanders sampled with children under the age of five who ride in a car, stated they use a child safety seat. This is a decrease from the 97.2% of those who participated in the 1995 survey. In terms of safety belt usage, 88.5% of the 466 Rhode Islanders sampled, stated their children ages 5-15 who ride in a care used a safety belt. This is an increase from the 75.9% figure from the 1995 survey. Of the 408 Rhode Islanders sampled with children under the age of 16 and who ride a bike, 56.6% reported their children always wear a bicycle helmet. This is an increase from the 1995 survey, when

only 32.7% of participants reported their children under the age of 16 always wore a bicycle helmet.

Children's Mental Health

The *2000 Rhode Island KIDS COUNT Factbook* states that in 1999, Rhode Island's eight community mental health centers provided services to a total of 6,885 children and youth. Butler Hospital provided services to an additional 1,265 children and youth in its outpatient and partial hospital programs. During the same period, Butler Hospital admitted 900 children and youth, 43% of whom were diagnosed with depressive disorder. Bradley Hospital, Rhode Island's largest psychiatric center for children and adolescents, admitted 912 children and youth to its programs for treatment of emotional disorders.

Child Deaths (see Section 2.5--for a more complete discussion)

During the five year period, 1995-1999, 158 Rhode Island children aged 1-14 died. The child death rate during this period was 17.0 per 100,000. Nearly two-thirds of these deaths, 103 (65.2%), were due to illness. The remaining one-third or 55 deaths were due to injuries, 45 (81.8%) of which were unintentional. Of the unintentional deaths, 16 involved motor vehicles, 11 were fire-related, and 4 were drownings. There were 9 homicides and one suicide. When deaths due to illnesses are disaggregated by individual cause (e.g., malignant neoplasms, congenital anomalies, heart disease, etc.), then unintentional injuries become the leading cause of death among children aged 1-14 in Rhode Island.

According to the Annie E. Casey Foundation's *2000 KIDS COUNT Data Book,* in both 1996 and 1997, Rhode Island had the lowest child death rate in the country.

PRIORITY: IMPROVE THE HEALTH, SAFETY AND OPTIMAL DEVELOPMENT OF ADOLESCENTS

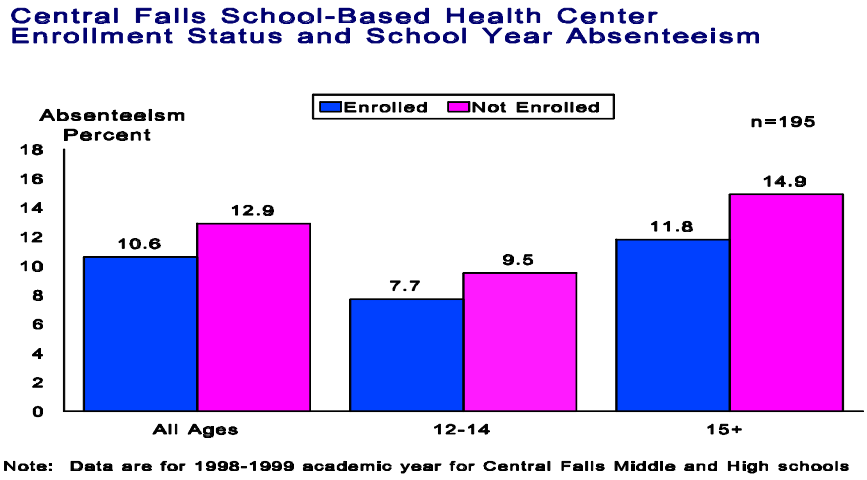
PRIORITY: REDUCE AND MANAGE PREGNANCY RISKS

PRIORITY: STRENGTHEN PARTNERSHIPS BETWEEN SCHOOL, NEIGHBORHOOD AND HOME

School-Based Health

In Rhode Island, there are 7 school-based health centers (SBHCs): 3 are located in high schools, 3 are located in middle schools, and one is located in an elementary school. A map illustrating the location of the SBHC's in Woonsocket (high, middle and elementary), Central Falls (high and middle), Pawtucket (high and middle), and Providence (high school) can be found on page 117 (Figure 42). During FY2000, an assessment of the School-Based Health Center Program was conducted. School attendance was examined in relation to SBHC enrollment among middle and high school students. Information on absenteeism was provided by school administrators from available student listings via random selection procedures. Students were divided into two groups according to SBHC enrollment status. Absenteeism was calculated as the number of school days missed during the school year divided by the total number of students. Findings from the Central Falls Middle and High School school-based health centers (n=195) are discussed below.

Students enrolled in the SBHC's had better attendance in all age categories compared with students not enrolled. Differences were most notable among students aged 15 and older, where those enrolled in the SBHC's attended school on average 5.6 more days than students not enrolled. Among students aged 12-14, those enrolled in the SBHC's attended school 3.2 days more than students not enrolled (Figure 36).



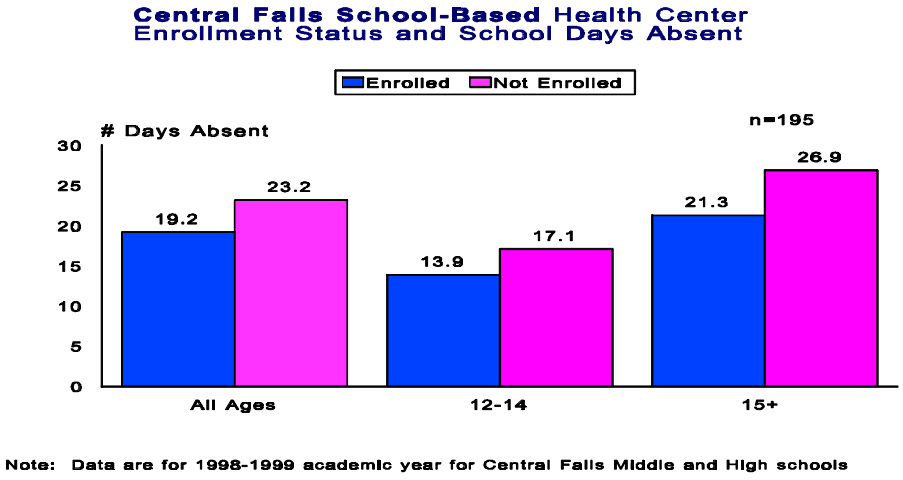


Figure 36

Absenteeism was also examined in relation to the total number of days available in the school year, by SBHC enrollment status and student's age. School-year absenteeism rates were defined as the average number of school days lost in each group divided by the number of days available in the school year. Figure 37 shows that students enrolled in the SBHCs experienced 2.3% less absenteeism in a year than those not enrolled.

Figure 37

Although differences were observed between the SBHC-enrolled and non-enrolled, it cannot be inferred that SBHCs reduce school absenteeism. Many factors contribute to absenteeism and reasons for the absences were not identified. An expansion of this assessment is planned in order to confirm these preliminary findings to: determine the main health problems influencing school attendance and educational outcomes; and assess the impact of SBHC□s in addressing the health needs of adolescents.

SALT (School Accountability for Learning and Teaching) Survey Data

In Rhode Island, a survey of all public school students, faculty and parents is conducted by the Rhode Island Department of Education to assess a variety of topics including: classroom instructional practices; perceived school climate and general quality of school life; family involvement in education; academic expectations; adjustment and self-esteem; health practices; school safety; homework and leisure reading; etc. The SALT survey was first conducted during the 1997-1998 academic year and has since been repeated during the 1998-1999 and 1999-2000 years.

A total of 81,664 students responded to the survey in 1998-1999, an increase from the 78,219 students who responded during 1997-1998. Of those responding to the 1998-1999 survey, 23,740 (29.1%) were in elementary schools (fourth and fifth grades only); 28,699 (35.1%) were in middle schools; and 29,225 (35.8%) were in high schools. Selected results from the 1998-1999 survey are described below.

Daily Stresses

- 32% of middle and 34% of high school students reported not getting along with other students.
- 32% of middle and 43% of high school students reported having problems with any of the following: acne, overweight; underweight; too tall and too short.
- 21% of middle and high school students reported being teased or bothered by other students.
- 12% of middle and 20% of high school students stated they were being pressured by friends to smoke, drink alcohol, or use illegal drugs.

School Safety

! Approximately one in three (33% elementary, 36% middle, and 26% high school) students surveyed reported being fearful of being hurt or bothered at school.

! Approximately one in four (28% elementary, 30% middle, and 24% high school) students also had experienced a theft or robbery at school.

! 10% of elementary, 8% of middle, and 7% of high school students reported having experienced actual violence at school.

! Nearly one in three (31%) high school students reported they had been offered drugs at school, compared with 14% of middle and 2% of elementary school students.

Family Involvement in Education

ÿ When asked whether their parents/guardians talk to them about why school subjects are important for the "real" world, 24% of elementary, 29% of middle and 39% of high school students reported their parents never or hardly ever did.

! 63% of high school students indicated their parents sometimes or often make sure they do their homework assignments compared with 83% of middle school parents and 93% of elementary school parents.

ÿ Less than half (42%) of the high school students reported their parents sometimes or often go to school activities or meetings compared with 43% of middle school and 63% of elementary school students.

Health Practices

ÿ Students who received free or reduced lunch reported they did not have a regular doctor or nurse twice as often as students who paid fully for their lunch. For instance, 18% of high school students who received free or reduced lunch reported they did not have a regular doctor or nurse compared with 9% of those who fully paid for their lunch.

ÿ 41% of elementary students who received free or reduced lunch reported they watched television more than 3 hours a day compared with 26% of students who paid fully for lunch.

ÿ 43% of middle school students who received free or reduced lunch and 27% of students who paid fully for lunch, stated they watched more than 3 hours of television a day.

ÿ 35% of high school students received free or reduced lunch and 24% of students who paid fully for lunch, stated they watched more than 3 hours of television a day.

Teen Family Planning/Averted Pregnancies

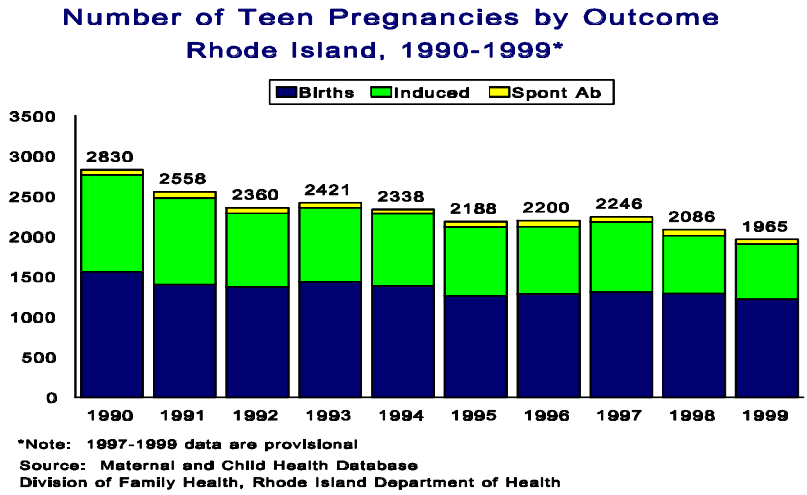
During 1999, 3,051 teens aged less than 20, received family planning services at a Title X-funded family planning clinic, representing over one-quarter (25.2%) of all family planning clients (12,099) during that period. The preferred choice of contraception among teens was the birth control pill, with 1,191 (39.0%) of the teen clients using that method of contraception. Condoms and depo provera were the next most frequently cited methods by the teens, with 564 (18.5%) using condoms 495 (16.2%) using depo provera. Approximately, 104 (3.4%) teens reported other methods, including norplant, IUDs, foam/ jelly/ cream, etc. However, 697 (22.8%) or nearly one-in-four were not using any method of contraception.

Based on the number of teens using contraceptives at the first clinic visit and the number of teens using contraceptives at their last visit in 1999, the number of pregnancies which were averted due to contraception can be calculated. The rate of expected pregnancies per 1,000 teen clients for each type of contraceptive multiplied by the number of clients using each method yields the number of expected pregnancies. Using this calculation, a total of 747 pregnancies were expected at the time of the teen clients first clinic visits. By the last client visit during 1999, only 346 pregnancies were expected due to an increase in the number of teen clients using contraceptives and the contraceptive method they were using. As a result of these calculations, it is estimated that 401 pregnancies to teens aged less than 20 were averted through family planning clinic visits.

Teen Pregnancy

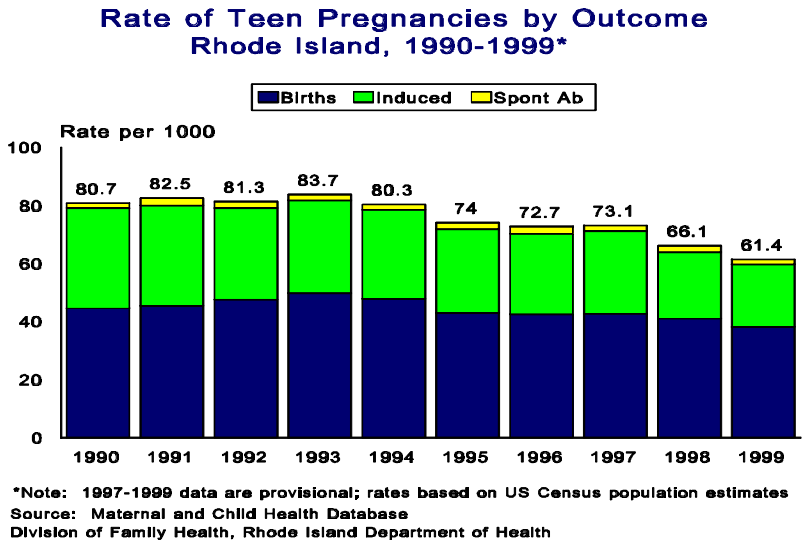
Since 1990, the number of pregnancies (live births, spontaneous abortions and induced abortions) among Rhode Island teens aged 15-19 has been declining. In 1990, there were 2,830 pregnancies and provisional data indicate that in 1999, there were 1,965, a 30.6% decrease (Figure 38). During this same period, the outcomes of teen pregnancies have changed, with more births and fewer abortions. In 1990, 1,565 (55.3%) of the pregnancies resulted in live births, 1,206 (42.6%) induced abortions, and 59 (2.1%) spontaneous abortions. In 1999, 1,222 (62.2%) of the pregnancies were live births, 688 (35.0%) were induced abortions, and 55 (2.8%) were spontaneous abortions.

Figure 38



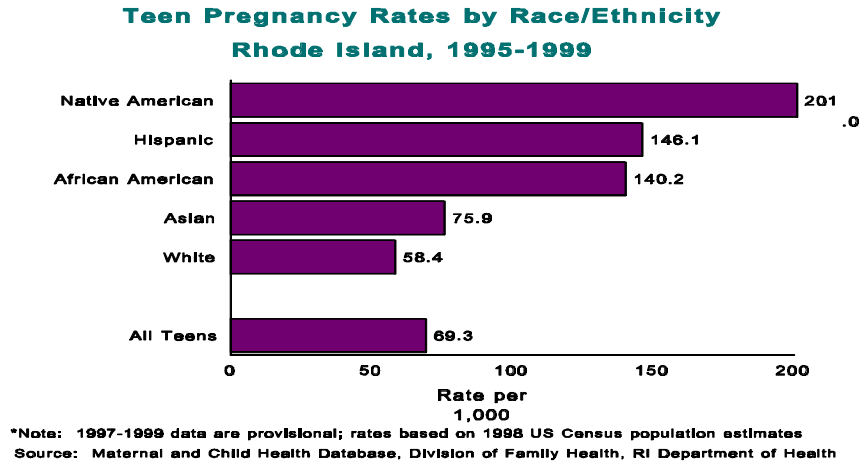
Rates of teen pregnancies have also declined during the 1990's. In 1990, the teen pregnancy rate among 15-19 year-olds was 80.7 and by 1999, the rate was 61.4 (provisional), a decrease of 23.9% (Figure 39). Rates are calculated based on US Census population estimates for each year. During the period between 1990 and 1995, the population of female teens aged 15-19 decreased 16%; however, during 1995-1999, the population increased 8%.

Figure 39



Although teen pregnancy rates have been decreasing, there is much variation among different racial/ethnic groups. Figure 40 illustrates the differences in teen pregnancy rates by race/ethnicity during the period, 1995-1999. Native Americans had the highest rate of teen pregnancy at 201.0 per 1,000, a rate that was nearly 3.5 times that of the 58.4 rate for Whites. Those of Hispanic/Latino ethnicity and African Americans had teen pregnancy rates that were more than twice that of Whites, with rates of 146.1 and 140.2, respectively. The teen pregnancy rate among Asians was 75.9, 30% higher than the rate for Whites.

Figure 40



Over half (56.8%) of the 10,685 Rhode Island teenagers aged 15-19 who became pregnant during 1995-1999 lived in the five core cities. Specifically, teens who lived in four of the five core cities had teen pregnancy rates which

were higher than the statewide rate (Figures 41 and 42). Teens living in Central Falls and Pawtucket had the highest pregnancy rates, nearly twice the statewide rate, at 132.0 and 107.8, respectively. Those residing in Newport did not have a rate higher than the state. Although teen pregnancy rates have been historically high among the core cities, high rates are now also being seen in other Rhode Island communities, such as West Warwick, where the rate during this period was 80.5.

Figure 41

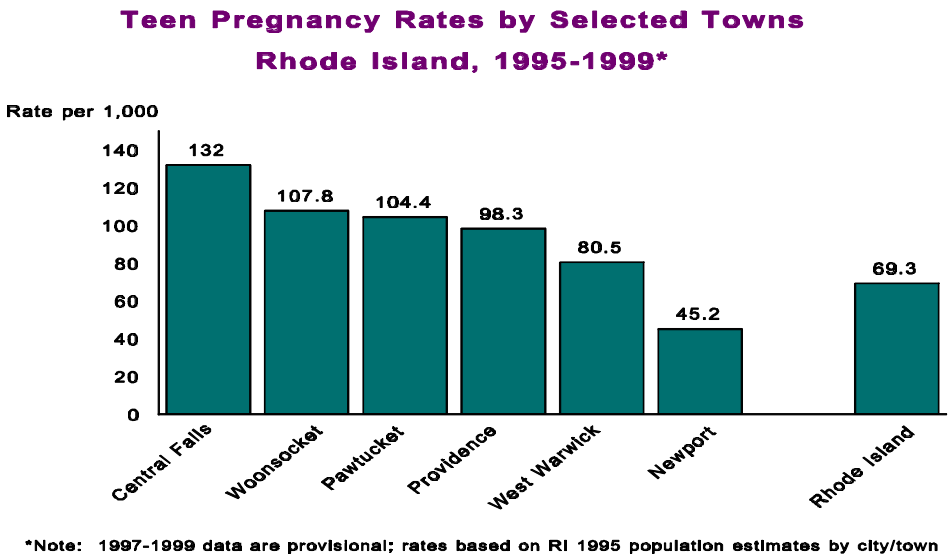
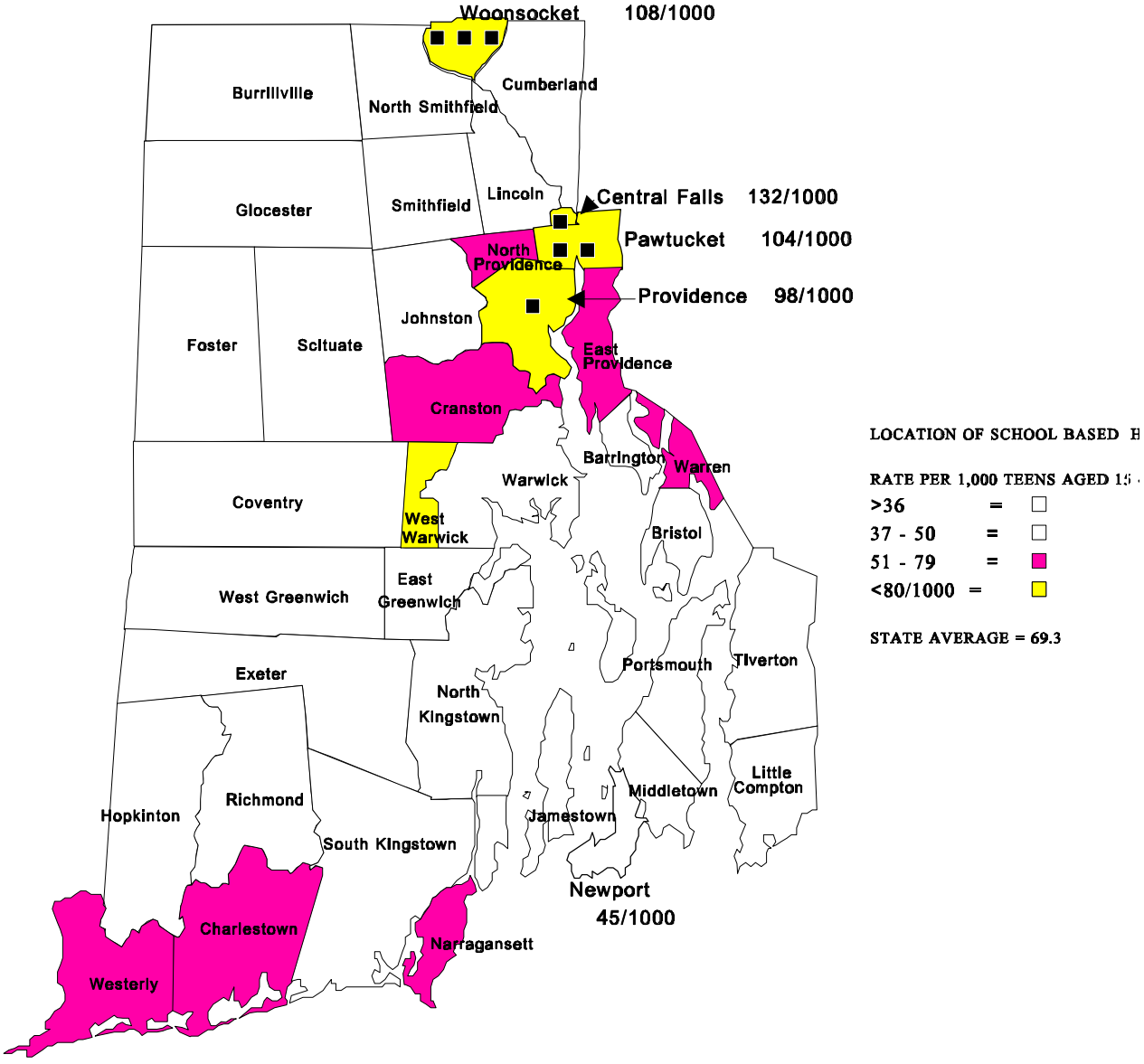


Figure 42

PREGNANCY RATES AMONG TEENS AGED 15 - 19
RHODE ISLAND, 1995 - 1999



NOTES: Pregnancy includes births, induced abortions and spontaneous abortions
Pregnancy Rate=number of pregnancies per 1,000 teens aged 15-19
SOURCE: Maternal and Child Health Database, Division of Family Health, RI Department of Health

Teen Pregnancies Among 15-17 Year-Olds

The number and rate of pregnancies among Rhode Island teens aged 15-17 also declined during the 1990's. Between 1990 and 1999 the number of teen pregnancies decreased 29%. In 1990, there were 908 pregnancies, of which 552 (60.8%) were live births, 338 (37.2%) were induced abortions, and 18 (2.0%) were spontaneous abortions. By 1999, there were 645 pregnancies, of which 412 (63.9%) were live births, 213 (33.0%) were induced abortions and 20 (3.1%) were spontaneous abortions. The rate of teen pregnancies among teens aged 15-17 decreased from 52.5 per 1,000 in 1990 to 33.6 in 1999, a 36.0% decrease. Specifically, the birth rate decreased from 31.9 in 1990 to 21.5 in 1999, a 32.6% decrease.

As described in the section on pregnancies among teens aged 15-19, there are disparities among racial/ethnic groups. During 1995-1999, Native American teens aged 15-17 had the highest birth and pregnancy rates compared to other racial/ethnic groups. The Native American birth rate (108.1) was five times that of the White rate (21.0), and the Native American pregnancy rate (118.5) was 3.5 times that of the White rate (33.2). Those of Hispanic/Latino ethnicity also had birth (81.9) and pregnancy rates (88.5) that were significantly higher than those for Whites.

According to the Annie E. Casey Foundation's *2000 KIDS COUNT Data Book*, which used 1997 data, Rhode Island had the 25th lowest teen birth rate (births per 1,000 female teens aged 15-17) in the country.

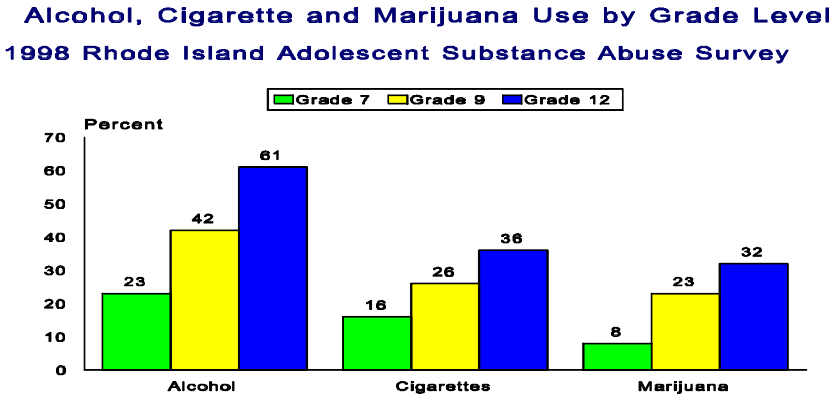
Teen Risk Behaviors

Rhode Island Adolescent Substance Abuse Survey (ASAS)

Data from the 1998 Rhode Island Adolescent Substance Abuse Survey (ASAS) indicate that alcohol is the leading substance of abuse at all grade levels in Rhode Island, and the prevalence of alcohol use among Rhode Island students is higher than national rates. Almost one in four (23%) Rhode Island seventh-grade students, 42% of ninth-graders, and almost two-thirds (61%) of twelfth-grade students reported using alcohol in the past month (Figure 43).

ASAS also revealed that 17% of seventh graders, 26% of ninth graders, and 36% of twelfth graders reported having smoked at least one cigarette in the past month. Almost half of all students reported that one or both parents smoked. Additionally, 8% of seventh graders, nearly one quarter (23%) of ninth graders, and nearly one third (32%) of twelfth graders, had used marijuana in the past month.

Figure 43

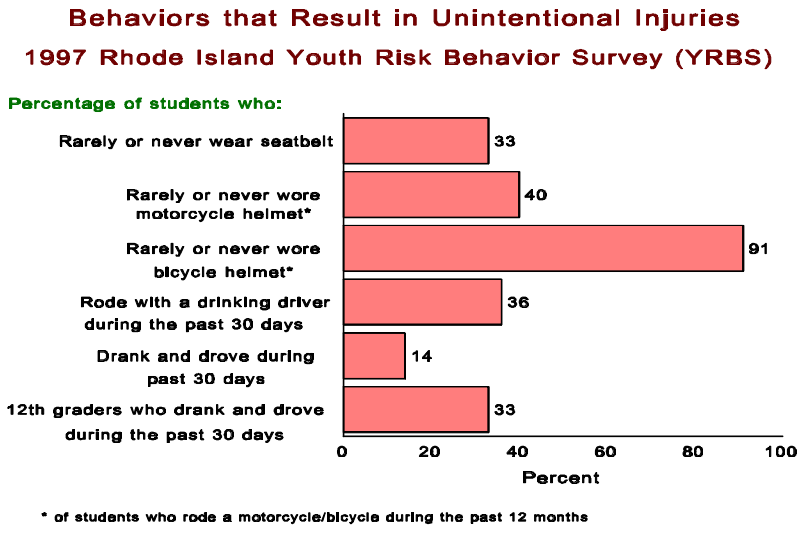


Rhode Island Youth Risk Behavior Survey (YRBS)

According to the 1997 Rhode Island Youth Risk Behavior Survey (YRBS), high school students (grades 9-12) are not only taking risks in the areas of tobacco, alcohol and drugs, but they are also taking risks with sexual intercourse, behaviors that may result in unintentional and intentional injuries. Of the 1,528 randomly selected Rhode Island public high school students, 43% stated they had sexual intercourse during their lifetime 31% stated they had sexual intercourse in the past three months. Of the student s who had sexual intercourse during the past three months, 52% reported they had used a condom during their last sexual intercourse.

Figure 44 summarizes the responses to questions pertaining to behaviors that result in unintentional injuries, such as seatbelt use, motorcycle/bicycle helmet use, riding with a drinking driver, and drinking and driving. Thirty-three percent (33%) rarely or never wore a seatbelt when riding in a car. Forty percent (40%) rarely or never wore a motorcycle helmet, while 91% rarely or never wore a bicycle helmet. Thirty-six percent (36%) reported having ridden in a vehicle driven by someone who had been drinking alcohol during the past 30 days, while 46% of 12th graders reported having done so. Fourteen percent (14%) of the students reported that in the past 30 days, they had driven a car when they had been drinking alcohol; while one in three (33%) of the 12th graders reported having done so.

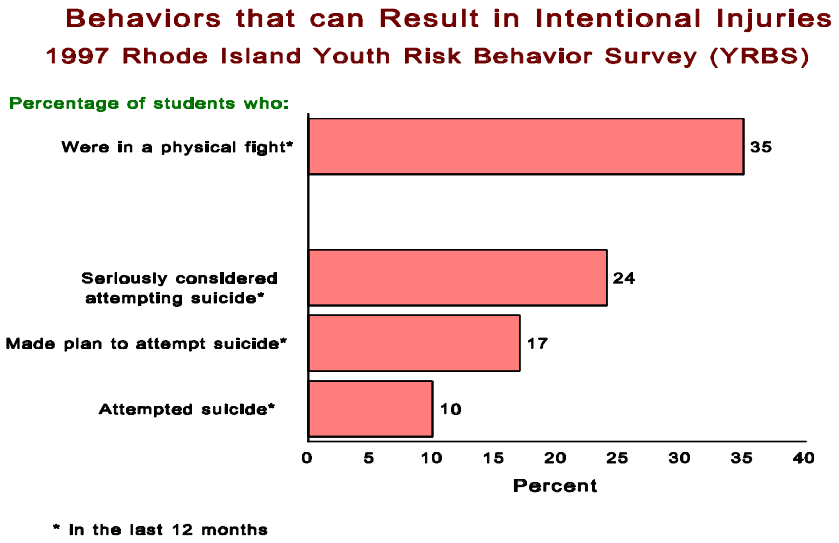
Figure 44



In terms of behaviors that could result in intentional injuries (Figure 45), 35% of students reported they had been in a physical fight during the 12 months preceding the survey. Nearly one in four (24%) students stated they had seriously considered attempting suicide during the past 12 months. Female students (30%) were more likely than male students (17%) to have considered attempting suicide. Seventeen percent (17%) had made a plan to attempt suicide, with a higher percentage of female students (21%) making a plan compared to 13% of male students. Ten percent (10%) reported

they had attempted suicide in the past 12 months. Females were twice as likely than males to have attempted suicide; 13% of females compared with 6% of males reporting they had attempted suicide.

Figure 45



Se

xually Transmitted Diseases (STD□s)

The number of Rhode Island female teens aged 15-19 with a reported case of chlamydia has been rising, although in 1999, there was a decrease. Between 1996 and 1998, the number of cases rose 17%, from 618 to 723. However, between 1998 and 1999, the number of cases dropped from 723 to 690. The rate of chlamydia (number of cases per 1,000 female teens) among Rhode Island teens rose 14%, from 20.4 to 23.3, between 1996 and 1997. However, since 1997, the teen chlamydia rate has been decreasing and in 1999, the rate was 21.6. The population of females aged 15-19 in Rhode Island has been increasing and therefore, although the number of chlamydia cases rose between 1997 and 1998, the rate actually decreased.

The rate of chlamydia among 15-19 year-olds is approximately four times higher than the rate among women aged 20-44. In 1999, the chlamydia rate among 20-44 year-olds was 5.6 and the rate for teens was 21.6. During 1996-1999, the chlamydia rate increased 17% among women aged 20-24, from 4.8 to 5.6.

Homeless Youth

According to the *2000 Rhode Island KIDS COUNT Factbook*, in Rhode Island between July 1998 and June 1999, 75 youth between the ages of 13 and 17 received shelter through the emergency shelter system in Rhode Island. Since many of the emergency and domestic violence shelters do not accept males over the age of twelve, this figure is most likely an underestimate of the number of youth in need of shelter.

Rhode Island does not have an overnight emergency shelter system for runaway youth. Travelers Aid data

indicate, however, that a total of 975 youth under the age of 22 accessed services through Travelers Aid during 1999. Of these, 253 (26%) were homeless; 326 (33%) were runaways;, 248 (25%) were in transitional arrangements (e.g., treatment centers, shelters, etc.); and 148 (15%) were considered to be at-risk for homelessness. Of the youth that received services from Travelers Aid, over half had dropped out of school; 40% were uninsured; 60% were presently or had been involved with DCYF; and 13% of the youth had children themselves. In 1999, the Travelers Aid Runaway Youth Project provided street outreach services in Providence, Pawtucket, Central Falls and Newport to 5,715 youth at-risk for homelessness or who were homeless/runaways.

In 1999, an average of 20 teen boys and 40 teen girls per month were in night-to-night placements. Night-to-night placements are temporary nightly placements of youth under the care of DCYF who are awaiting permanent foster care placement, group home/treatment placement, or who have run away from their current placement. As of December 1999, there were 114 youth in DCYF care who were classified as unauthorized absences/runaways.

School Attendance/Suspensions

According to the *2000 Rhode Island Kids Count Factbook*, poor school attendance affects school achievement and can lead to school failure. In Rhode Island, during the 1998-1999 school year, 92.5% of students enrolled in public schools (kindergarten through 12th grade) attended school, based on average daily attendance. Students enrolled in Providence schools had the lowest attendance rate of 87.1%. A study of Providence students entering first grade in 1987 found that only 45% were still with their peers by 5th grade and fewer than 25% progressed with their peers to 12th grade. By 12th grade, more than half of the 1,845 children who entered first grade in 1987, had either moved to another community, transferred to a private school, returned to their family of origin, or dropped out of school altogether.

During the 1998-1999 school year, there were 44,701 incidents in which a Rhode Island public school student received a suspension, alternative placement or expulsion. More than half (54.4%) of the disciplinary actions were out-of-school suspensions. The most common category of infractions resulting in disciplinary action was minor offenses (72.4%), followed by disorderly conduct (9.9%), and fighting (6.0%). Responses from the 1998-1999 SALT Survey indicate that 18% of high school, 14% of middle and 8% of elementary students who received free or reduced lunch were served out-of-school suspensions. These figures are higher than those for students with full paid lunch, where 11% of high school, 8% of middle, and 1% of elementary students were served out-of-school suspensions.

High School Graduation

High school graduation rate is defined as the percentage of the ninth-grade class that is expected to graduate based on the existing drop-out incidence among 9th, 10th, 11th and 12th grade students. In 1999, the Rhode Island the high school graduation rate was 83%. Rates varied by community with the core cities having the lowest rates. Central Falls had the lowest rate at 58%, followed by Pawtucket at 66%, Providence 71%, Woonsocket 75%. However, Newport, with a graduation rate of 87%, was higher than the statewide rate.

SALT Survey data indicate that 84% of high schools students who received free or reduced lunch, expected they would definitely or probably graduate from high school; 90% of high school students with full paid lunch expected to graduate. Responses were similar among middle school students, but expectations of high school graduation were

lower among elementary students. Only 74% of elementary students who received free or reduced lunch expected they would graduate high school and 86% of those with full paid lunch expected to graduate.

Teens Not in School and Not Working

In 1997, 11% of Rhode Island teens aged 16-19 were not enrolled in school and not working, thereby placing Rhode Island 40th in the country, as ranked by the Annie E. Casey Foundation's *2000 KIDS COUNT Data Book.* Since 1990, the percentage of teens aged 16-19 not in school and not working has risen 22%. In 1990, 9% of Rhode Island teens aged 16-19 were not in school and not working and Rhode Island was ranked 19th in the country. Teens who are not in school and not working are at especially high risk for teen parenting, crime, negative behaviors, and limited economic prospects.

Juveniles Referred to Family Court

According to the *2000 Rhode Island KIDS COUNT Factbook*, the Rhode Island Family Court has jurisdiction over all juvenile offenders referred for wayward and delinquent offenses. All referrals to Family Court are from state and local law enforcement agencies, with the exception of truancy cases which are referred by local school departments. In 1999, 4,402 juveniles aged 10-17 were referred to Juvenile Court for 7,901 offenses. Since 1998, the number of juveniles referred to Family Court has decreased 6% (from 4,700 in 1998), and the number of offenses has decreased by 15% (from 9,272 in 1998).

During 1988-1997, the number of juvenile violent crime offenses in Rhode Island increased from 272 to 613, a 125% increase. However, since the peak in 1997, the number of violent crime offenses has decreased to 432 in 1999, a 29.5% decrease. Between 1990 and 1999, violent crime offenses accounted for 5.3% of all offenses for youth aged 10-17. Juveniles residing in the five core cities accounted for 57% of all juvenile crime in 1999 and for 42% of all juveniles referred for any offense. The juvenile crime rate, including the rate for violent crimes, decreased in the core cities between 1997 and 1998.

As of December 1, 1999, there were 186 youths at the Training School, which is 7% over capacity. During 1999, a total of 1,157 youth passes through the Training School.

Teen Deaths

In Rhode Island during 1995-1999, 148 teens aged 15-19 died, resulting in a teen death rate of 47.0 deaths per 100,000 teens. Although during the 1990's the number of teen deaths decreased, the rate of teen deaths remained stable since the population of 15-19 year-olds has been decreasing. For instance, during 1987-1991, there were 183 teen deaths and the teen death rate was 47.1. Annual figures show that the number of teen deaths in Rhode Island overall has been decreasing. However, due to small numbers, there have been year-to-year fluctuations. For instance, during 1987-1996, the number of teen deaths declined steadily from 44 teen deaths in 1987 to 20 in 1996. However, in 1997, the number of teen deaths rose to 45, but dropped back down to 28 in 1998 and 29 in 1999.

Unintentional injuries were the leading cause of deaths among teens. Of the 148 deaths that occurred among Rhode Island teens during 1995-1999, 61 (41.2%) resulted from unintentional injuries. Nearly two-thirds, 38 (62.3%)

of the unintentional injury deaths were due to motor vehicle accidents. The other leading causes of death were illnesses (44), homicide (25), and suicide (18).

Gun-Related Deaths and Hospitalizations

During 1994-1998, 23 teens aged 15-19 died as a result of guns and 92 were hospitalized. Younger children (aged less than 15) also died or were hospitalized as a result of guns during 1994-1998, where 4 children died and 18 children were hospitalized. Two-thirds (67%) of the gun-related hospitalizations were among Providence residents.

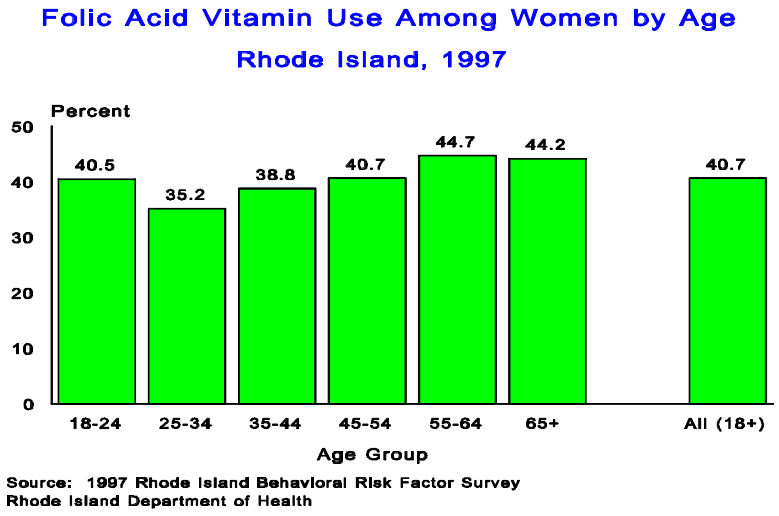
C. Children with Special Health Care Needs

PRIORITY: EXPAND ACCESS TO GENETIC SERVICES DURING THE PRECONCEPTION AND PRENATAL PERIODS

Folic Acid Consumption

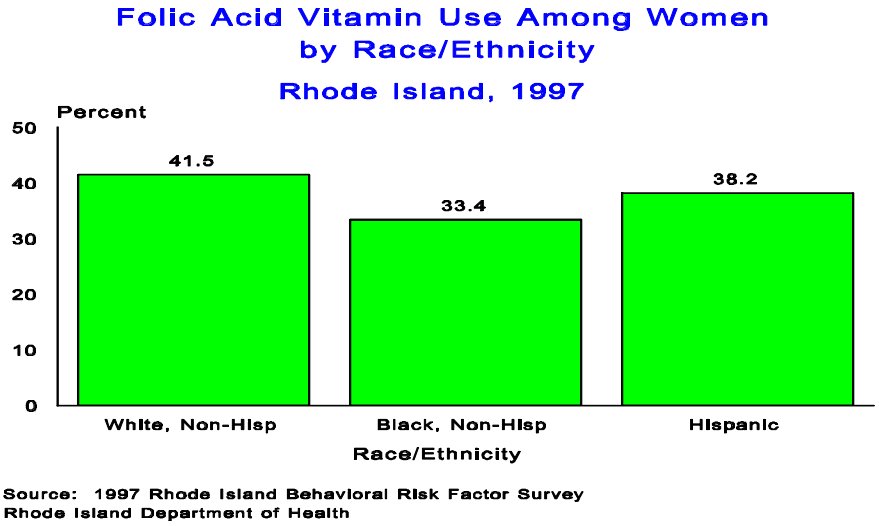
According to the Health Department's 1997 Behavioral Risk Factor Surveillance Survey, 40.7% of women ages 18 and older currently take a multivitamin or vitamin containing folic acid. This figure varies by age and race/ethnicity. The survey indicated that women aged 25-34 had the lowest folic acid consumption, where only 35.2% stated they took a vitamin with folic acid. Women over the age of 55 had the highest rate of folic acid consumption, where more than 44% were taking folic acid (Figure 46).

Figure 46



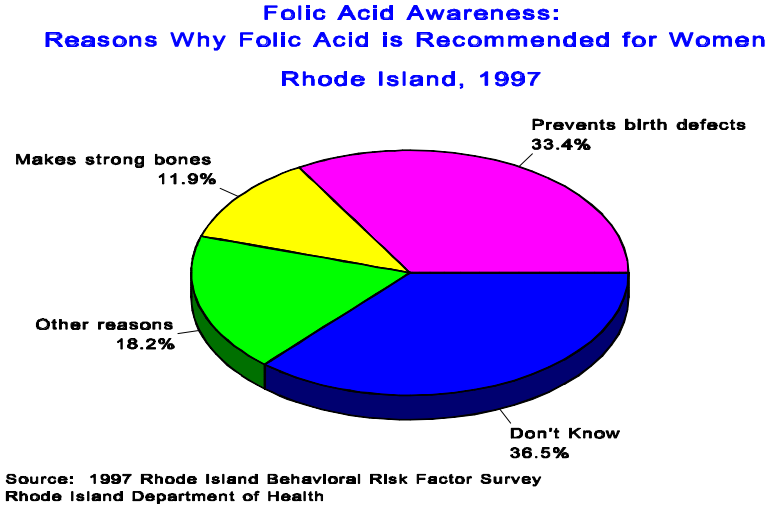
African American women had lower rates of folic acid vitamin use compared with Whites and Hispanics, where 33.4% stated they took folic acid compared with 41.5% of Whites and 38.2% of Hispanics (Figure 47).

Figure 47



When women surveyed were asked why folic acid was recommended, over one-third (33.4%) said to prevent birth defects, nearly 12% said to make strong bones, 18% listed other reasons and 36.5% did not know (Figure 48).

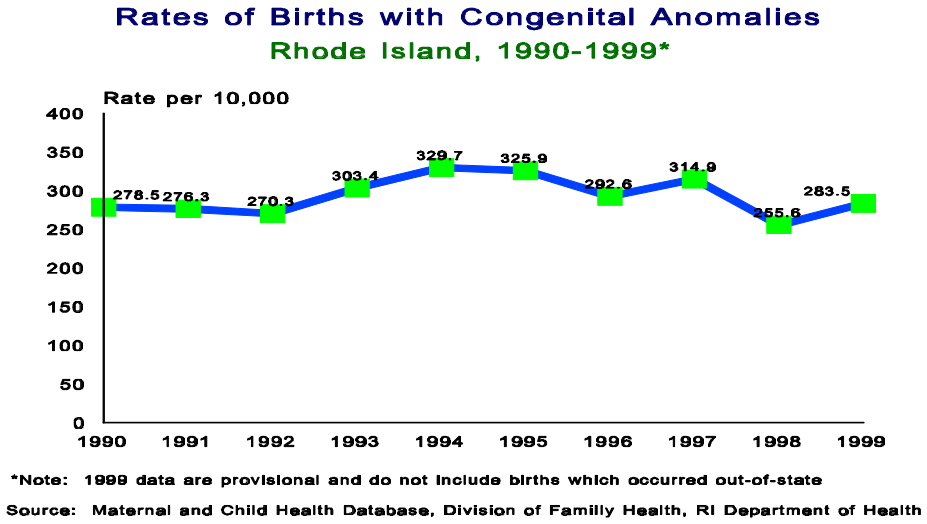
Figure 48



Congenital Anomalies

During the 1990's, the rate of Rhode Island babies born with congenital anomalies has flucutated (see Figure 49). Rhode Island vital statistics data indicate that during 1990-1994, the rate rose from 278.5 per 10,000 births in 1990 to a high of 329.7 in 1994, an 18% increase. During the period 1995-1999, there appears to have been a decrease in the congenital anomaly birth rate. During these five years, 1,839 babies were born with congenital anomalies resulting in a congenital anomaly rate of 295 per 10,000 births. Specifically, in 1995, 416 Rhode Island babies were born with congenital anomalies, a rate of 326 per 10,000 babies; in 1999, 339 babies were born with congenital anomalies, a rate of 283 per 10,000. Although this represents a 13% decrease, the data for 1999 are provisional and do not include births to Rhode Island women that occurred out of state.

Figure 49



During 1995-1999, the category of congenital anomalies which had the greatest number of babies identified, n=444, was muskuloskeletal/integumental anomalies which include cleft lip/palate and club foot. The second highest anomaly group was urogenital, with 398 babies identified (Table 64). Table 4 shows the ten most frequent congenital anomalies in Rhode Island for 1999. These ten accounted for 256 (75.5%) of the 339 congenital anomalies among births in 1999.

Table 64: Births with Congential Anomalies by Body System, Rhode Island, 1995-1999*

Congenital Anomaly	Number	Rate/10,000
Musculoskeletal/Integumental (cleft lip/palate, club foot, polydactyly, etc.)	444	71.1
Urogenital	398	63.8
Circulatory/Respiratory (heart malformations, etc.)	303	48.5
Central Nervous System	79	12.7
Chromosomal (Down's Syndrome, etc.)	76	12.2
Gastrointestinal	57	9.1
Other	482	77.2
TOTAL	1839	294.6

*Note: 1997-1999 data are provisional; 1999 data do not include births which occurred out-of-state
Source: Maternal and Child Health Database, Division of Family Health, RI Department of Health

Table 65: Ten Most Frequent Congenital Anomalies Rhode Island, 1999*

Congenital Anomaly	Number	Rate per 10,000 live births
Other Urogenital Anomalies*	70	58.5
Other Musculoskeletal/Integumental*	46	38.5
Other Circulatory/Respiratory*	33	27.6
Polydactyly/Syndactyly/Adactyly	24	20.1
Club Foot	24	20.1
Heart Malformations	17	14.2
Down Syndrome	12	10.0
Cleft Lip/Palate	10	8.4
Malformed Genitalia	10	8.4
Other Central Nervous System	10	8.4
Total Ten Most Frequent	256	214.1
1999 Total Births with Anomalies	**339**	**283.5**

*Notes: 1999 data are provisional
Other Urogenital Anomalies = all those except malformed genitalia or renal agenesis.
Other Musculoskeletal/Integumental Anomalies = all those except cleft lip/palate, polydactyly/ syndactyly/adactyly, club foot, and diaphragmatic hernia.
Other Circulatory/Respiratory Anomalies = all those except heart malformations.
Source: Maternal and Child Health Database, Division of Family Health, Rhode Island Department of Health

Rates of births with congenital anomalies differed by racial/ethnic groups. During 1995-1999, African

Americans and those of Hispanic/Latino ethnicity had the highest congenital anomaly rates. The rate of congenital anomalies among African Americans was 25% higher than the rate for Whites, 363 per 10,000 live births compared with 290 per 10,000 live births. Native Americans and Asian Americans had the lowest rates of congenital anomalies, with rates of 241 and 240, respectively.

Mortality

Provisional data show that during 1998, of the 88 infant deaths among Rhode Island residents, 24 (27.3%) resulted from a birth defect. The birth defects specific infant mortality rate for Rhode Island during 1998 was 190.5 per 100,000 live births. Compared to 1993, the proportion of infant deaths resulting from a birth defect and the birth defects specific infant mortality rate have increased slightly. In 1993, 24 (23.5%) of the 102 infant deaths resulted from a birth defect; and the birth defects specific infant mortality rate was 171.8 per 100,000 live births. These data show that between 1993 and 1998, the birth defects specific infant mortality rate increased by 10.9%. This trend has occurred while the proportion of babies born with congenital anomalies has decreased which may indicate that fewer babies born with congenital anomalies are surviving beyond their first year of life.

Resources

Children with birth defects are evaluated and followed at the Child Development Center at Rhode Island Hospital. Clinics are available for most birth defects, including meningomyelocele, Down Syndrome, inborn errors of metabolism, and multiple other syndromes. The Cardiology Clinic is a pediatric specialty clinic at Hasbro Children's Hospital. Rare conditions are referred to Boston specialists.

Open Neural Tube Defects Study

During FY2000, the Division of Family Health (DFH), Women and Infants Hospital Prenatal Diagnosis Center (PDC) and the Rhode Island Hospital Child Development Center (CDC) conducted a study with the Foundation for Blood Research Coordination Center to determine the prevalence of open neural tube defects (open spina bifida and anencephaly) in Rhode Island and to assess the outcomes of pregnancies identified through alpha-fetoprotein (AFP) screening which were determined to have an ONTD. Data were obtained from the following sources: vital statisitcs, to determine the number of live births and their diagnoses; the PDC (which tests approximately 50% of the state's population of pregnant women), to determine the number of pregnancies screened, number determined positive for ONTDs, and number of pregnancies terminated; and the CDC's Spina Bifida Clinic, to determine any additional cases.

Diagnoses were obtained for the 97,713 live births which occurred among Rhode Island residents during 1991-1997. After the birth data were compared with the PDC screening data , 99 pregnancies were identified (10.1 per 10,000 births) with ONTDs; 54 (5.5 per 10,000) had open spina bifida (OSB) and 45 (4.6 per 10,000) had anencephaly. Of the 99 pregnancies with ONTDs, 48 (48.5%) had been screened, 45 (93.7%) of whom were ONTD positive, and 34 (75.6%) of the ONTD positives were terminated. Specifically, 30 (55.6%) of the 54 OSB cases were screened; 27 (90%) of those screened were positive; and 16 (59.3%) of the positives were terminated. Of the 45 births with anencephaly, 18 (40%) were screened, 18 (100%) were positive and all were terminated.

More than half, 51 (51.5%) of the 99 pregnancies with ONTDs were not screened, and 28 (54.9%) were terminated. Specifically, of the 24 OSB's not screened, 6 (25.0%) were terminated and of the 27 anencephaly pregnancies not screened, 22 (81.5%) were terminated.

These data can be used as a baseline before the introduction of grain products fortified with folic acid to look at the impact of folic acid supplementation on the occurrence of ONTDs. Studies have shown folic acid supplementation can reduce the occurrence of ONTDs. This study is viewed as a pilot for a future birth defects surveillance system which Rhode Island is interested in developing. Funding is being sought to develop a surveillance system that will include neural tube defects, as well as other birth defects.

Newborn Developmental Risk Screening

Data from the Universal Newborn Developmental Risk Screening Program indicate that in 1999, of the 11,931 Rhode Island babies screened for developmental risks, 4,835 (40.5%) were determined to be at risk for developmental delays. A baby is determined to be at risk if they have any one of the following criteria: a known established condition; birth weight less than 1,500 grams; a neonatal intensive care unit (NICU) length of stay greater than 48 hours; or a positive HBSG. A baby may also be determined to be at risk if they meet at least two of the following criteria: mother's age is less than nineteen or greater than 37; mother's and/or father's education is less than 11th grade; mother is not married; no previous live births; five previous live births; presence of at least one family history risk factor; number of prenatal visits before 36 weeks is less than 6 or total number of prenatal visits is less than 10; no prenatal care visits before the fifth month; gestational age is greater than 37 weeks and birthweight is between 1,500 and 2,500 grams; APGAR scores less than 7 at one and five minutes.

Babies born to families residing in the core cities, except Newport, were more likely to be determined to be at risk for developmental delays (Figure 50). Nearly two-thirds (65.7%) of the babies born to Central Falls residents, and more than half of the babies born to Providence (59.6%); Pawtucket (52.9%) and Woonsocket (52.4%) residents were determined to be at risk.

Babies who are determined to be at risk are offered home visits and are provided referrals to appropriate services. During 1999, of the 4,835 risk positive babies, 2,750 (56.9%) received a home visit. Figure 51 illustrates the proportion of risk positive babies born in 1998 that received a home visit within one year of birth by city/town. Towns with less than 160 births were excluded. In 1998, 55.7% of risk positive babies received a home visit within one year of birth. Ten towns fell below that proportion, including Woonsocket, where 52.0% of risk positive babies received home visits. Several factors contribute to this percentage, including refusals of home visiting services. Four towns (Providence, Cranston, Bristol, and Newport) fell into the 55.7%-60.9% range. Five towns, including Central Falls, had 65% or more of their at-risk babies receive a home visit within one year.

In 1999, 689 (5.7%) of the 11,979 Rhode Island babies screened were hospitalized in the NICU for more than two days. Of these 689 babies, 427 (62.0%) were low birth weight. This represents a 14% rate of increase from 1995, when 54.2% of babies with NICU stays of more than two days were low birth weight. In 1995, very low birth weight babies represented 13.3% of NICU stays of more than two days and by 1999, they represented 21.3%, a 60% rate of

increase. The proportion of very low birth weight babies that had NICU stays of more than two days also rose during 1995-1999. In 1995, 73% of very low birth weight babies had NICU stays of more than two days and by 1999, this figure rose to 84.5%, a 16% rate of increase. The proportion of babies weighing 1500-2499 grams with NICU stays of more than two days decreased from 44.0% in 1995 to 39.2% in 1999, an 11% decrease.

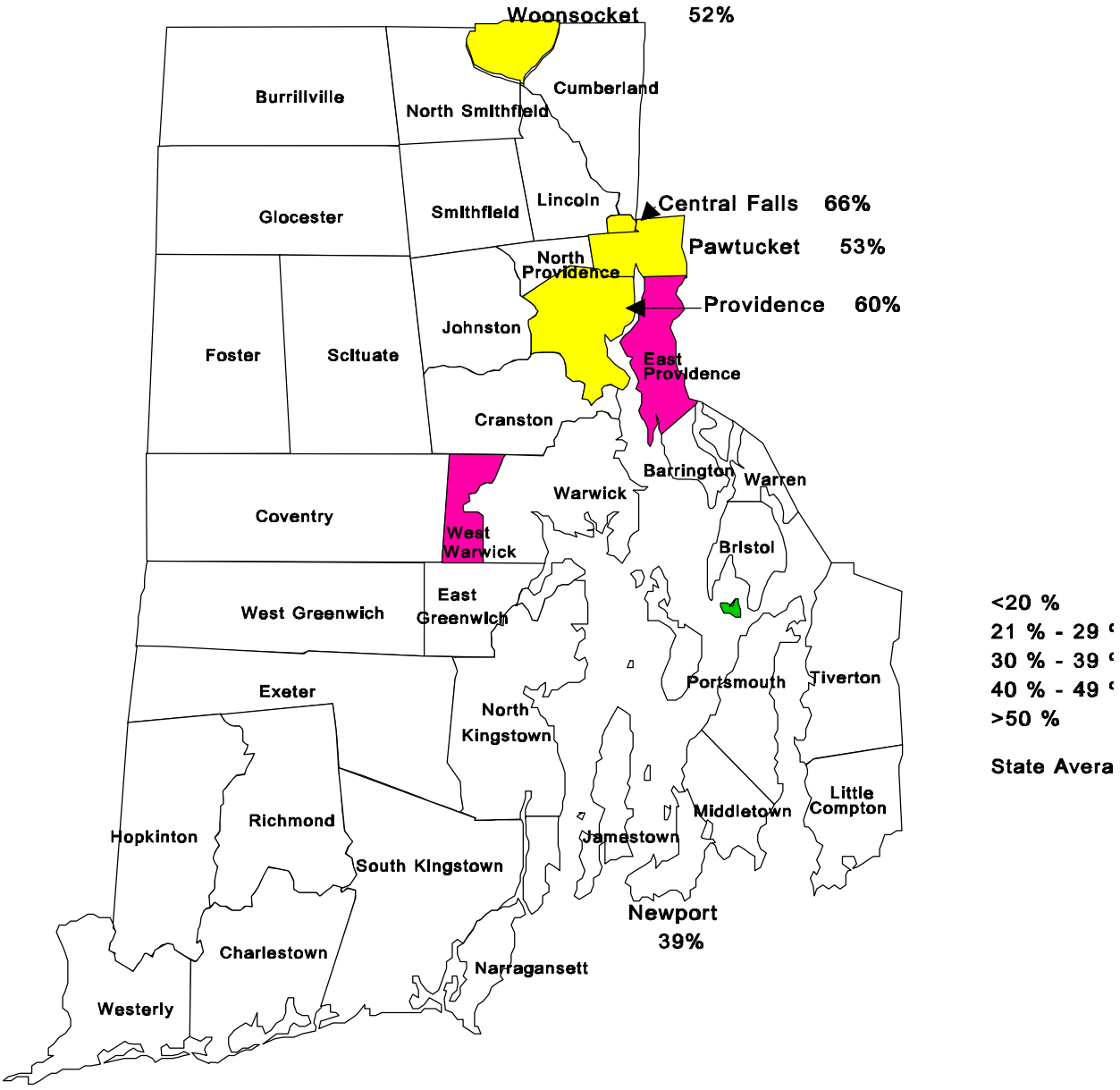
Universal Newborn Hearing Assessment

In Rhode Island, 99% of babies receive hearing assessments. Data from the Rhode Island Hearing Assessment Program (RIHAP) show that between July 1, 1995 and June 30, 1998, 40,748 babies born in Rhode Island were screened for hearing. Of these babies, 37,409 (91.8%) passed, 2,595 (6.4%) failed, 560 (1.4%) had incomplete screens or were lost, and 184 (0.5%) died. There was a higher rate of screen failures among males (7.4%) than females (5.6%). Non-white infants had a higher rate of failure (4.9%) than Whites (3.7%).

During the period, July 1995-June 1998, failure rates have been decreasing . During FY96, 8.5% of newborns failed, during FY97, 6.3% failed, and during FY98, 4.0% failed.

Figure 50

Proportion of Newborns Determined to be At-Ri
Rhode Island, 1999

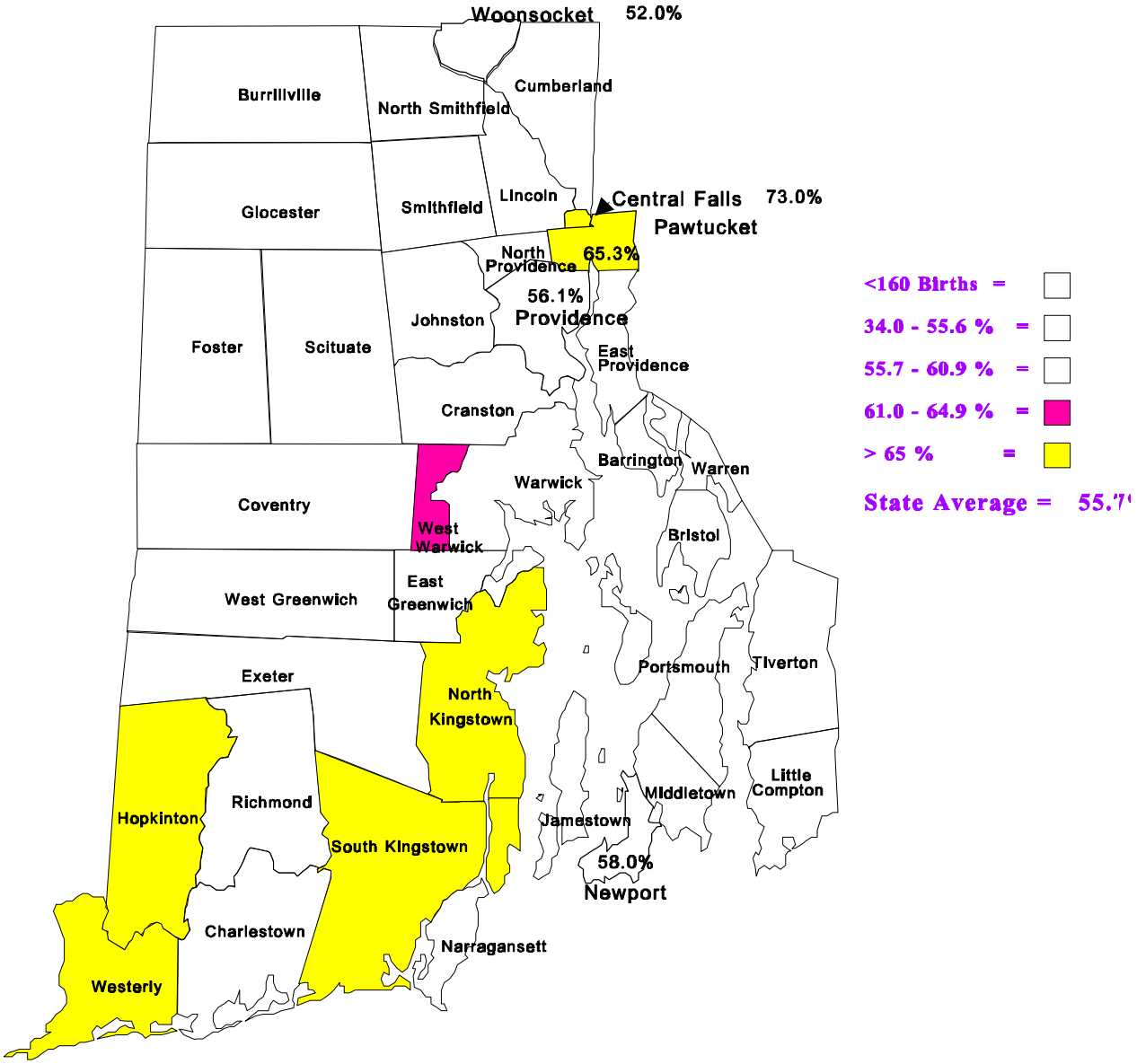


SOURCE: Universal Newborn Developmental Risk Screening Program

Figure 51

Proportion of At-Risk Infants Who Received a Home Visit within One Year of Birth

Rhode Island, 1998



NOTE: Towns with less than 160 births were excluded

SOURCE: Universal Newborn Developmental Risk Screening and Home Visiting Programs

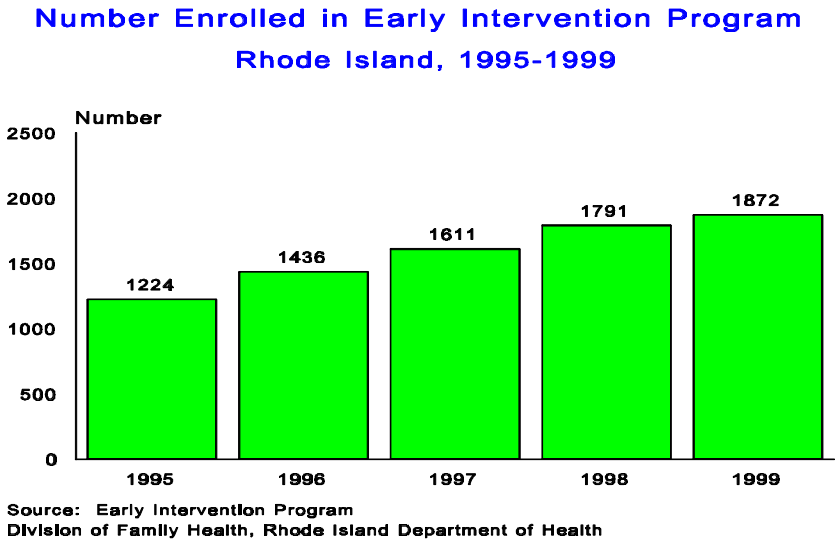
PRIORITY: ASSURE ACCESS TO APPROPRIATE SERVICES DURING PERIODS OF TRANSITIONS FOR CSHCN

PRIORITY: ASSURE EACH CHILD HAS A MEDICAL HOME THAT ASSURES TIMELY, COMPREHENSIVE AND COORDINATED PREVENTIVE SERVICES AND LINKS TO SUBSPECIALTY CARE

Early Intervention (EI)

The number of children, aged birth to three, enrolled in the Early Intervention Program has continued to rise. In 1995, 1,224 children were enrolled in the program and by 1999, this number had risen to 1,872 children, a 53% increase (Figure 52). Many factors have resulted in this increase, including earlier identification of children requiring early intervention services. Programs such as Universal Newborn Screening (Level I) and Home Visiting Risk Response have contributed to the early identification and referral of children to the Early Intervention Program. Additionally, the survival of very low birth weight infants and the increase in multiple gestation births have also contributed to the increases in EI enrollment.

Figure 52

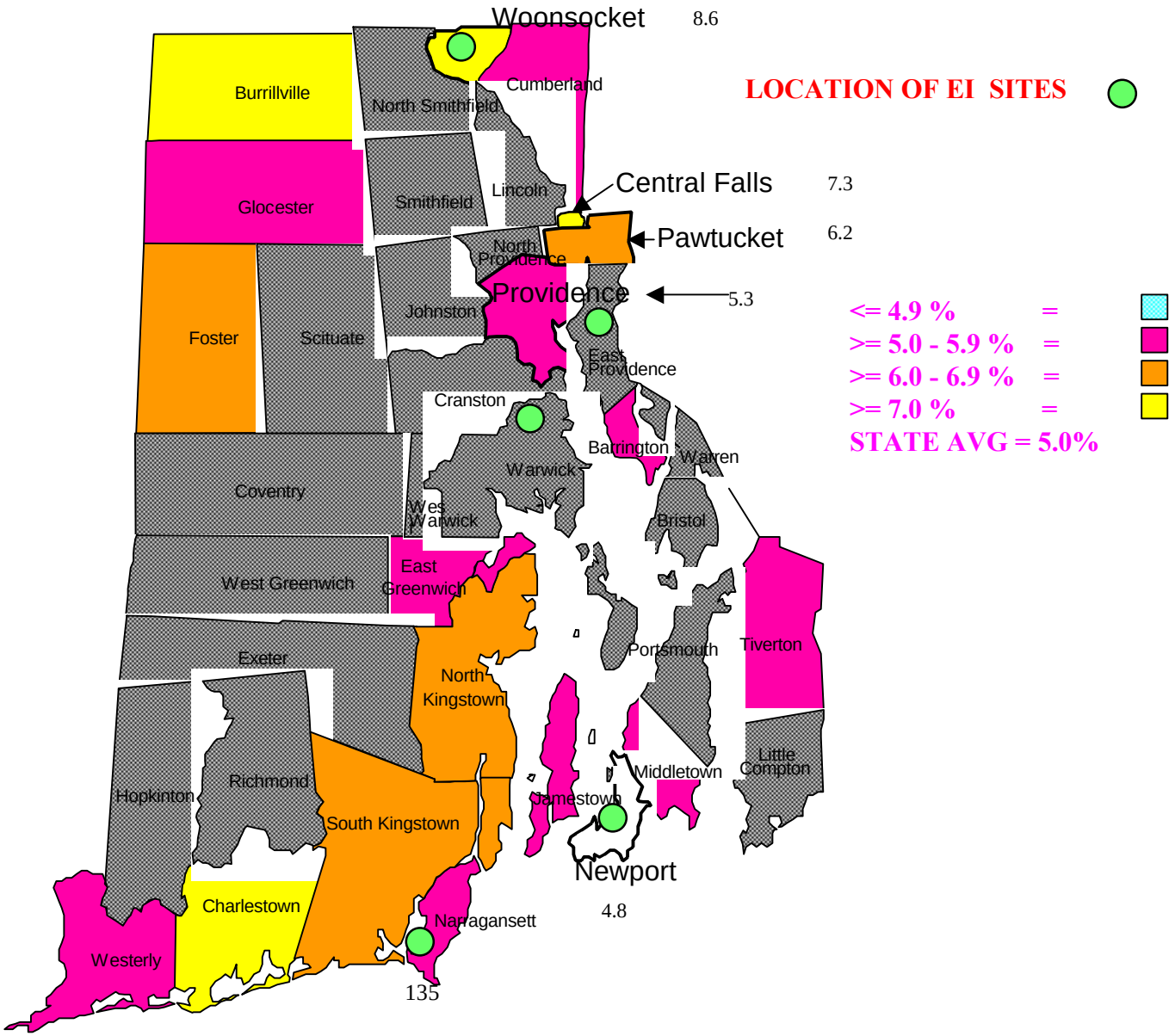


In 1999, of the 1,872 children enrolled in EI, 218 (11.7%) were infants, 403 (21.5%) were aged one, and 1,248 (62.8%) were aged two or older. Nearly two-thirds (65%) of the EI enrollees were White; 17% were of Hispanic ethnicity; 7% were African American; 1% were Asian; and less than 1% were Native American.

Figure 53 shows the proportion of children aged birth-3, enrolled in Early Intervention and the location of the five EI service sites. Overall, 5% of the state's birth-3 population, were enrolled in EI during 1999. This figure varies by city/town where, for instance, 8.6% of Woonsocket's birth-3 population were enrolled in EI compared with 4.8% of Newport's.

FIGURE 53

PROPORTION OF CHILDREN AGED BIRTH - 3 ENROLLED IN EI RHODE ISLAND 1999



A study of children who were born in 1995 and enrolled in the Early Intervention Program yielded the following. Of 1,117 children who had intakes completed 308 (27.6%) were aged one or less; 309 (27.7%) were aged between one and two; and 489 (43.8%) were above age two. Most, 963 (86.2%), of the 1,117 who had an intake went on to have an evaluation. Of those evaluated, 808 (83.9%) were determined to be eligible for the Early Intervention services; 97 (10.1%) were determined ineligible; and 58 (6.0%) families declined enrollment.

The majority of the 808 who were determined to be eligible for Early Intervention went on to have an Individualized Family Service Plan (IFSP), where 782 (96.8%) had an IFSP. Nearly three quarters, 559 (71.5%), of those with an IFSP were diagnosed with developmental delays. More than half, 451 (57.7%), of those with IFSPs remained in the Early Intervention Program for one year or less; 180 (23.0%) remained for a period of one to two years; 106 (13.6%) remained for a period of two years or more; and 45 (5.7%) were not discharged to date, according to the information system. Nearly half, 333 (45.2%) of the 737 children who were discharged from the Early Intervention Program went on to special education; 181 (24.6%) no longer required services; 78 (10.6%) moved out of state or to another region; 73 (9.9%) refused additional service; and 72 (9.8%) were unable to be contacted or their status was unknown.

Cost of Early Intervention Services

An assessment was conducted to determine the average cost of services provided to children enrolled in EI. During FY99, 1,676 enrollees received 28,149 service visits at a cost of $2,651,910 resulting in an average cost of $1,582 per child enrolled in EI. Services which represented the highest number of visits were: service coordination (7,453), speech therapy (5,022), physical therapy (2,892), and occupational therapy (2,783). Together these four services accounted for 18,150 visits, nearly two-thirds (64.5%) of the total number of visits by EI enrollees. These services also represented the highest costs, where speech therapy ($622,860), service coordination ($514,955), physical therapy ($355,800), and occupational therapy ($335, 880) represented $1,829,495 (69.0%) of the total service costs.

Special Education

According to the *2000 Rhode Island KIDS COUNT Factbook*, during the 1998-1999 school year, there were 28,993 Rhode Island children, aged 3-22, with disabilities who received special education services. This figure represents 14.2% of the 203,807 total student population. Of those who received special education services, more than two-thirds (69.7%), were classified as learning disabled. This is an increase from the 1997-1998 academic year, when 54% of special education students were classified as learning disabled. The local school system is responsible for identifying and evaluating students between the ages of 3 and 22 with disabilities and who might require special education.

Traumatic Brain Injury

Data from Rhode Island's Traumatic Brain Injury registry indicate that during 1995-1997, 1,122 children aged less than 18 were hospitalized for a brain-related disease or injury, 24 (2.1%) of whom died. Of the 1,098 who were discharged alive, 627 (57.1%) were hospitalized for a brain-related disease, while 471(57.1%) were hospitalized for a brain-related injury. Of the 471 hospitalizatioins for brain injuries, 349 (74.1%) had an intracranial injury without a

skull fracture and 122 (25.9%) had an intracranial injury with a skull fracture. The majority of the 471 children with brain injuries were discharged home, where 416 (88.3%) were discharged home, 38 (8.1%) were transferred to other institutions, and 17 (3.6%) were discharged home with professional care.

Children with Disabilities

The Rhode Island Medicaid program currently purchases health, behavioral health, and residential services for 4,960 children with disabilities. These children represent 3.6% of the total Rhode Island Medicaid program, and 4.6% of total program expenditures. Children with disabilities include children with: physical disabilities, developmental disabilities, serious emotional disturbances, and foster children with disabilities. Children with disabilities experience a broad range of chronic conditions that include differences in clinical manifestation, severity, and impact on age-appropriate activities such as growth, play, and learning.

Children with the following diagnoses are among those who meet the SSI criteria for disability:

- AIDS
- Spina bifida
- Cerebral palsy
- Downs Syndrome
- Serious emotional disturbances
- Autism
- Brain injury
- Severe asthma
- Leukemia
- Cystic fibrosis
- Multiple congenital anomalies
- Juvenile diabetes
- Severe depression
- Severe respiratory disease

Approximately 5% of children with disabilities are newborns or infants under the age of one. Many of these children are placed in NICUs at birth, and the majority has some kind of physical disability. Another 18% are pre-school aged and receive services in the community through early intervention programs or kindergartens. The vast majority of children with disabilities (78%) are school-aged children and receive services from their families, the medical care system, and the school system. Most of these children have some form of developmental disability. Within the school-age group, a large number (23%) of children with disabilities in Rhode Island are older adolescents between the ages of fifteen and seventeen. The older children are more likely to have a serious emotional disturbance. One of the biggest challenges in serving these children is preparing them for life as young adults, maximizing their potential to work and live independently.

Children with disabilities often receive a broad range of services which often include home and community-based services; behavioral health services; and/or hospital-based acute care services. They receive services from a range of pediatric specialists, and most of these services are provided at tertiary care centers, specifically teaching hospitals. Because their care needs are often very complex, many children with disabilities do not have community-based primary care providers, but rely on specialists for much of their primary care.

Another area where children with disabilities seem to receive fewer services than other children, or even other adults with disabilities is dental care. Only 22% of the children received dental services in six months. Even if this number doubled over a twelve-month period, it still means that fewer than half of all children with disabilities receive

dental care.

Behavioral Health Services

Children with disabilities are ten times as likely to use community mental health center (CMHC) services as they are to use licensed therapists outside the CMHC setting. Approximately 13% of children with disabilities used mental health services during the study period, and some of these children require intensive services. The majority of children's mental health services are provided through contracts administered by DCYF. The services provided range from outpatient counseling and family support, to inpatient care, crisis intervention, out-of-home diversion services, and specialized residential care.

The families of children with disabilities need support and concrete assistance, which is often provided by family service agencies or home health providers. The most severely disabled children also receive private duty nursing services, a benefit not available to adults covered by Rhode Island Medicaid. These nursing services are often responsible for preventing institutionalization.

(From: "Medicaid: Population-Basd Overview", *Governor's Advisory Council on Health, Final Discussion Draft, 1998-1999*)

Limitation of Activity--Rhode Island Health Interview Survey

Results from the 1996 Rhode Island Health Interview Survey indicated that approximately 2.4% of children aged less than five had a limitation in the kind or amount of play activity. Of children between the ages of 5 and 17, 3% were limited in any activity; 5.4% were limited in the kind or amount of school activity; and less than 1% were unable to perform major activities.

Health Care Needs of Children with Disabilities on Medicaid

In the fall of 1997, a survey was conducted to better understand the needs of Rhode Island children with disabilities on Medicaid. The *Caregiver Survey* interviewed a statewide samrple of 257 caregivers of children aged 1-21 with physical, mental and developmental disabilities. The survey findings included the following:

- 53.3% of the children had two or more disabilities; 49.5% needed help with their personal care; 73.7% were limited in the kind or amount of activity they can do; and 7.1% were unable to take part at all in age-appropriate activities.

- 85.6% of the children had a preventive health visit in the past year. On average, children with disabilities received 2.5 primary care visits; 3.4 acute primary care visits; and 18.2 specialty care visits for a total of 24.1 health care visits per year. Children with developmental disabilities had 12.6 specialty care visits per year, physical disabilities had 15.8 and mental disabilities had 29.3.

- Overall children with disabilities had 2,693 emergency department admissions per 1000. Children with physical disabilities had the highest number of emergency department admissions at 4,729 per 1,000. The hospitalization rate for children with disabilities was 417 per 1000 children. Children with physical disabilities had the highest hospital admission rate at 700 admissions per 1000 children. However, children with mental disabilities have the highest number of days spent in the hospital. Of children who were hospitalized, children with mental disabilities, on average, spent 72.6 days in the hospital per year, compared with 24 days for children with physical disabilities and

only 3.2 days for children with developmental disabilities.

ÿ Overall satisfaction with care was high, where 95% of caregivers stated they were satisfied or very satisfied with their care. They were most likely to feel overwhelmed due to their child's needs, unable to work due to caretaking responsibility, unable to find child care and not able to get support from family and friends.

ÿ The most significant unmet needs related to needs for support and ancillary services to caregivers. These needs included parent support groups, respite care, information on primary condition, parent education, transportation and day care. Unmet direct care needs for the child included case management, dental care and mental health counseling.

(From: "Health Care Needs of Children with Disabilities on Medicaid: Results of Caregiver Survey", Final Report prepared by Jane Griffin for Rhode Island Departments of Human Services and Health, June 8, 1998)

Community Input

Although Rhode Island has excellent data for its needs assessment, we believe statistics only present a partial picture of family health needs in Rhode Island. To truly understand the needs of Rhode Islanders, we need their input. Our community input is gathered from community meetings, a public hearing, and family surveys.

Community Meetings/Public Hearing

During Spring 2000, Division staff presented our Title V Plan, *Family Health in Rhode Island*, to a variety of community and professional organizations, and families, in order to solicit their input. Additionally, we held a public hearing, the results of which are described in Section 4.3.

Surveys

The Division has enhanced its capacity to conduct telephone surveys on specific maternal and child health issues. In addition to conducting the Food Security Survey which was described earlier, the Division has also been conducting a survey of families with children aged 10-16. This is part of an effort to better understand the issues surrounding communication between parents and teens. The goal of the survey is to track changes in knowledge, attitudes, and practices of adults regarding their relationships, including their communications, with teens. The Division has committed to an intiative to promote positive images of youth, and improve adult-teen relationships. The main component of the initiative is a multi-year public engagement campaign.

The survey targets adults and is a random digit dial telephone survey conducted statewide. The survey focuses on two groups: parents raising children between ages 10-16, and adults in general. To date, nearly 300 respondents have completed the survey. Results from this survey will also function as the baseline prior to the implementation of a media campaign which will focus on adult perceptions of and communications with teens. The survey will be repeated after the campaign is completed to determine the campaign's impact.

The Division also is conducting a survey of adolescents, much like the survey described above, to assess their perceptions of adult-teen relationships. This adolescent survey is being implemented through a contract with Youth in Action, a community-based youth organization. The survey uses a convenience sample of teens in the greater Providence

area. We anticipate approximately 100 teens will complete the survey, which will be implemented during FY2000.

The Division is also about to launch a Prenatal Genetic Services Survey to learn what services were offered and/or received during the prenatal period by families who have children with a genetic-related condition. The tool, developed by the Genetics Services Task Force, will be piloted at the Rhode Island Hospital Child Development Center in July 2000.

3.1.2.2 Direct Health Care Services

Like other states, Rhode Island has entered a period of rapid medical care system reform, in which the state is attempting to expand access and coverage, largely through Medicaid waivers, employer-funded commercial coverage is diminishing, and all sectors are moving rapidly to cost constrained managed care mechanisms. The state's Medicaid managed care program, RIte Care, has had a profound impact on the state's health care system. Recently, coverage under RIte Care was expanded through the federal Children's Health Insurance (CHIP) to include children up to age 18 (and 19 if still in school) if their family income is less than 250% of poverty. In addition, a new state law requires RIte Care to cover immigrant children whose parents are in the country illegally. It is estimated that 15,000-20,000 children are eligible for RIte Care, but remain unenrolled. State law has also expanded eligibility to include pregnant women with incomes up to 350% of poverty; parents of children with a family income up to 185% of poverty; and child care providers who serve low income children. By July 2000, RIte Care had 108,000 enrollees. The number of enrollees is expected to grow. However, there is evidence that as many as 20,000 Rhode Islanders left their more costly private health insurance plan to enroll in RIte Care. The rapid increase in the RIte Care caseload has caused the Department of Human Services to predict a combined shortfall of $46.3 million for fiscal years 2000 and 2001. In July 2000, the state's House of Representatives approved a plan to slow RIte Care's growth. The Senate is expected to approve this plan in the near future.

RIte Care has also shifted where the Medicaid population receive care. RIte Care is not limited to community health centers and enables enrollees to receive care from private doctors. Information from the RIte Care data base, from community surveys, and from public forums confirms that more pediatric practices have enrolled low income children. Surveillance data on prenatal care and immunizations show that Rhode Island's already high performance is improving. Managed care contracts require information in multiple languages, interpreters, and other efforts to improve access.

Nonetheless, there have been problems. Families with special needs children have been largely "carved out" of the initial Medicaid reforms. Access to specialty services has, however, become more complicated for many special needs families, with tightened referral controls in both public and commercial coverage. The disenrollment and appeal difficulties in SSI are complicated by the fact that SSI children are "carved out", and revert to Medicaid Managed Care plans if they lose SSI eligibility. This can destabilize the already challenging coordination of a special needs child's medical care.

In reaction to the these problems, the Rhode Island Department of Human Services has created an initiative, the CEDARR Program Initiative, which will define a set of services for children with special health care needs which it will

purchase from certified providers. It is intended that through these arrangements, DHS will ensure timely access to appropriate, high quality services for CSHCN. CEDARR stands for Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation services and supports. The initiative is part of a Statewide Vision for Children and Families with Special Needs, developed by the Leadership Roundtable on Children with Special Needs, a representative group of family members, providers, public and private administrators, and advocates. CEDARR includes two broad provider components: CEDARR Family Centers and CEDARR Certified Direct Services and Support Providers.

Although the Department of Health and the Title V program have not been major providers of clinical care services for several decades in Rhode Island, we have been heavily engaged in the long term development and monitoring of the health care systems organization and performance. We have made strategic investments and policy commitments to an integrated community primary care capacity for all (widespread community health centers, statewide home visiting, school based preventive investments, etc.). These community networks, to provide primary care, family support, early intervention, school services, etc., are, we believe, the foundation for Rhode Islands good results in maternal and child health. These coordinated community health resources remain in place, but many of them are quite dependent on patient and revenue flows that are changing rapidly with managed care. Therefore, medical care reform, especially in Medicaid, can threaten a community integrated MCH infrastructure. We are working hard to be at the table with state policy forums, managed care leaders, professional groups, etc. to address these issues and assure ongoing attention to the needs of children and families.

We maintain population surveillance for all childrens developmental and preventive services, and we are installing an interactive electronic information system called KIDS NET in all providers offices. The Department has the infrastructure, authority, and current resources to manage and monitor these population-based services. They are a very high priority on the Departments agenda. However, there could be issues with their long term financing if we faced severe budget cuts, and there are controversies about these population and surveillance services in the discussions of competition and information ownership in a managed care environment.

3.1.2.3 Enabling Services

Enabling services are, so much as possible, seen as part of a seamless comprehensive health care system that includes primary and specialty physicians, nursing, nutrition, social work, dental care, and all the special skills required for children with significant disabilities. Most managed care contracts, especially RIte Care, reflect this broad inclusion of enabling services, although there are specific system capacity and access issues (for dental care, physical and occupational therapy, and a few medical specialties) our overall health system capacity and availability appears good. Managed care has diminished the perceived freedom to chose providers for some families, but has improved access for many. If larger groups of special needs children, including SSI, are switched to Managed Care, this issue will become much more intense.

Oral Health (see also Infrastructure Building Services)

Access to oral health services for low income children is a problem in Rhode Island. Problems with

transportation, communication, and child care often prevent Medicaid recipients from keeping their scheduled appointments. Long distances between the home and the dental offices accepting Medicaid clients combined with a reliance on public transportation creates difficulties for some individuals in making their scheduled appointments. In addition, as many as 30% of Medicaid households in Rhode Island do not have telephone service, and approximately 20% of Rhode Island households that receive Medicaid do not use English as their primary language. These barriers may contribute to a high number of missed appointments.

Many dentists feel that Medicaid reimbursement rates for dental services are inadequate. As a result, many dentists are unwilling to accept Medicaid patients, at least to any significant degree. In addition to low reimbursement rates, the reasons cited by Rhode Island dentists for not participating in the Medicaid program include an excessive number of patients who fail to keep appointments; excessive paperwork; payment delays; poor communication with the state agencies; and patients with complicated medical, social, and behavioral problems.

Approximately 370 (52%) of practicing dentists in the state accept Medicaid patients. However, the majority of private dentists who take any Medicaid clients limit their practices to less than two Medicaid patients per week.

In Rhode Island there are 704 licensed dentists, and dental practices can be found in almost every city and town. However, the availability of dental services varies considerably between localities. In some areas of Rhode Island there are shortages of dentists.

There are five "Dental Health Professional Shortage Areas" (DHPSAs) in Rhode Island (Table 66).

Table 66: Rhode Island Dental Health Professional Shortage Areas (HPSAs)

Location	Population Group Studied
Newport County (Newport, Portsmouth, Middletown, Tiverton, Little Compton, Jamestown)	Low Income Population
Central Falls/Pawtucket (Census Tracts 108-111,149, 151-153, and 161)	Low Income Population
Providence (Census Tracts 1-23, 25-33, and 35-37)	Low Income Population
East Washington County (South Kingstown, North Kingstown,Narragansett)	Low Income Population
Northwest Woonsocket (Census Tracts 172, 174, 176, and 178-183)	Low Income Population

3.1.2.4 Population-Based Services

Although we do not provide clinical care, and we are very selective in our support of medical services in a state

with high levels of comprehensive insurance, the Rhode Island Department of Health does maintain key population prevention and surveillance services. We provide the full package of vaccines free of charge to all children. We finance lead screening for all children. Within our Communications and Policy Unit, we continue to maintain our MCH Information Line which receives nearly 2,500 calls per year. Information Line staff respond to questions and information requests and also are able to survey Rhode Islanders on key issues. The Communication and Policy Unit has also worked with Family Health program staff to develop media campaigns on topics including immunizations, lead poisoning, and adolescents.

The Department is deeply committed to maintaining the information base and timely interactive surveillance capacity, as part of a larger core public health agenda to assure knowledge for health decisions and quality of health services. In these matters, we work closely with a variety of cabinet level policy forums (the Children's Cabinet, the Danforth Policymakers Group, Carnegie Starting Points, etc.). We are also deeply committed to Rhode Island Kids Count, which has become the shared information environment for children's policy development statewide, and the dissemination arm for Title V needs assessment data. Rhode Island Kids Count is an autonomous 501c3 organization, with broad roots in universities, business, and medical leadership, as well as state cabinet linkages.

3.1.2.5 Infrastructure Building

The majority of the Division of Family Health's investments are in infrastructure building. To assure a statewide system of family-centered, community-based, culturally competent and coordinated services to preserve, protect, and promote the health and development of children and their families, the Department has committed to a parent development and local systems development strategy. Our emphasis is on public engagement, parent education, Starting Points, and Child Opportunity Zones, and the broad integration of our WIC, Early Intervention, Family Planning, and other investments into community systems building forums. Over the last five years, under the overall guidance of the Children's Cabinet, Rhode Island has committed to family centers in all neighborhoods with substantial concentrations of vulnerable children. There are now 32 Child Opportunity Zoned family centers, with the expectation that this number will increase to 70-100 in the next few years. A COZ/family center provides a local focus for all our efforts to engage parents, assure health, safety and optimal child development, and bring all children to school ready to learn. Combined with school based and linked health services, Healthy Start, and a variety of other growing commitments to adolescent and young adult prevention, we have a strategy at the neighborhood level to address the other high cabinet priority--to assure success and safety, so that all youth shall leave school prepared to lead productive lives.

Finally, we are deeply engaged with many colleagues in both state and community forums to assure that all families shall be safe in their homes, neighborhoods, and schools. In these forums, we bring the Title V, Part C of IDEA, SSDI, WIC, and school health mandates. Most of these forums include representation from the Department of Human Services (Medicaid, Child Care, Welfare Reform) and the Department of Children, Youth and Families (Child Welfare, Children's Mental Health) and the Department of Education. They also include the academies and colleges of medical specialization, and often a representation of major community provider agencies. In general, we are attempting to avoid categorical and discipline-specific system development and policy forums, in favor of more broadly integrating

all the stakeholders and contributors. This is reflected in our community family service development forums, and our state level policy forums. As a small state with no county structure, even state forums are often remarkably local in their focus. Although the overall Children's Cabinet outcomes and strategic commitments are well described, there are still a variety of forums in which policy discussions occur and there is not always a sense of coordination or even meaningful participation of all stakeholders when decisions are made. We continue to struggle with this challenge.

Oral Health

Nearly one half of Rhode Islanders (approximately 540,000 people) have dental insurance coverage, which includes 144,000 Medicaid eligibles. The Rhode Island Medicaid program offers dental coverage for child and adult recipients, although children have greater benefits due to EPSDT requirements. In addition, Rhode Island State Law (16-21-9) requires that school children receive dental examinations regularly. Every student in kindergarten through sixth grade is required to have an annual dental examination by a dentist. But thereafter every student is required to be examined only once at the secondary level (examinations are available annually). In addition, the federal Head Start and Medicaid programs require that children receive regular dental screenings and treatment when necessary.

The Medicaid dental benefit is operated under a fee-for-service system for all Medicaid recipients, including those enrolled in RIte Care. Rhode Island has one of the highest Medicaid utilization rates at 33%, however, this is still considered low by non-Medicaid standards. One major reason for low utilization, as cited by dentists, is the low Medicaid reimbursement rates. Rhode Island Medicaid dental reimbursement rates are approximately 45% of dentists' usual, customary, and reasonable (UCR) fee levels.

C*ommunity Health Centers with Dental Clinics*

Six community health centers in Rhode Island currently provide dental services and are listed in Table 6 below. The dental clinics operated by the community health centers have a total of 28 operatories. Many of the clinic staff members are bilingual. In total the clinics are staffed by 7.65 FTE dentists and 6.65 FTE hygienists.

Hospital-Based Dental Clinics

The two hospital-based dental clinics in the state are located at Rhode Island Hospital and St. Joseph's Hospital. Rhode Island Hospital is the site of the Samuels Dental Clinic. The clinic accepts Medicaid coverage, private insurance, and uninsured patients on a sliding scale basis. Samuels provides general dentistry for developmentally disabled children and adults. Emergency dental services are also provided for non-developmentally disabled adults. St. Joseph's Hospital is the site of the Pediatric and Family Dental Center. The Center opened in 1995 and accepts Medicaid, private insurance, and self-pay. Table 67 below indicates that during 1999, there were 5.5 dentists and 5.5 hygenists serving a total of 5,007 children at the two hospital clinics.

Table 6: Survey of Rhode Island Community Health Center and Hospital Dental Clinics October 1999

Site	Dental FTEs	#Child Patients	%Children in Practice	#Dental Operatories	#Underutilized Operatories	Appointment Wait Time

St Joseph Hospital*	2.5 DDS 3.0 RDH	3,685*	83%	8 (3@schools)	0	
RI Hospital Samuels Dental Center	3.0 DDS 2.5 RDH	1,322	40%	10	3	6 weeks for restorative; 10 weeks for recall; no wait time for emerg
Travelers Aid	Volunteer DDS 1.0 RDH	NA	NA	2	NA	NA
Providence Community Health Center	None at this time: Dentist on maternity leave and no RDH	NA	NA	6	6	NA
Thundermist Health Associates, Woonsocket	1.4 DDS 2.2 RDH	1,300	44%	5	0	6 weeks for routine appts (expected to decrease with RDH); 0-1 day for emergency
Blackstone Valley Health Center *	2.0 DDS 1.75 RDH	1,522	62%	5	.25	NA
New Visions Newport Cty	1.2 DDS 1.0 RDH	394	31%	3	.20	NA
Health Center of South County	0.8 DDS 0.4 RDH	889	42%	5	NA	10 weeks for routine appt; 0-1 day for emergency
Wood River Health Services	2.25DDS 1.3 RDH	757	40%	4	0 need additional	3-4 weeks for routine appts; 0-1 day for emergency
Total	**13.1 DDS 12.1 RDH**	**9,869**		**42**		

*St Joseph Hospital data includes Providence Smiles Program which served 1,185 children in selected Providence elementary schools.
*Blackstone Valley Community Health Care also operates a dental clinic at Central Falls high school two days a week as part of its SBHC clinic.
Other dental services include: Traveler's Aid; The Providence School-Based Dental Health Project; the Donated Dental Services Program; and Thundermist Health Care Center-Adolescents with Disabilities.

Other Dental Services

During the 1995-96 school year, over 90% of Rhode Island's Head Start Children received dental exams. Seventeen percent (17%) were found to be in need of treatment, but only half of these actually received the services indicated. In Rhode Island, the Department of Health's 1996 Health Interview Survey suggests that people with

disabilities are less likely to access dental care compared to the non-disabled general population. Adolescents with disabilities are at increased risk for virtually every dental problem, which accentuates the importance of preventive dental care and routine dental checkups.

Mental Health

Children's Behavioral Health

Publicly-funded mental health services for children (birth through age 21) are provided by the Rhode Island Department of Children, Youth and Families (DCYF) through contracts with private organizations and clinicians, and by the Department of Human Services through contracts with the health plans that participate in the RIte Care program.

The Department of Children, Youth and Families arranges and monitors a continuum of therapeutic and clinical services for seriously emotionally/behaviorally disturbed children and youth. It also provides an array of community-based therapeutic/supportive services aimed at maintaining healthy family functioning. Children who are placed in the custody of the Department due to abuse, neglect, and dependency, as well as children, who remain in the custody of their parents or legal guardians, are eligible for these services. Most services are delivered in community-based settings and are accessed primarily through the eight Community Mental Health Centers (CMHCs).

Components of the publicly supported mental health system for children include: certified mental health clinicians, day treatment programs, residential counseling centers, residential treatment, children's intensive services, psychiatric hospitalization, purchase of service, and diagnostic assessment services.

Medicaid is a major payer for mental health services in Rhode Island and an important source of support for the CMHCs. As described above, Medicaid funding is directed to the public mental health provider network primarily via MHRH on behalf of adults with serious and persistent mental illness and by DCYF on behalf of children with severe emotional or behavioral disorders.

Mental health services are also provided through RIte Care as part of the managed care benefit plan. Each health plan provides and manages mental health services to its enrollees through its own in-house provider network. The State and the health plans share the risk of covered high cost mental health services via stop-loss provisions in the RIte Care contract. Annually, more than 6,000 RIte Care enrollees receive mental health services through their plan.

Community Mental Health Centers (CMHCs)

In Rhode Island, CMHCs are the backbone of the publicly funded mental health system. The CHMCs are private non-profit agencies that provide mental health services with a particular emphasis on community-based alternatives to institutionalization. Each CMHC is governed by a board of directors. There are eight CMHCs in Rhode Island plus three additional entities (Riverwood, North American Family Institute, and Fellowship Health Resources) that contract with the State to serve persons with SPMI. These 11 organizations employ 1,827 staff members with a total salary of $53.4 million. Each CMHC is responsible for providing non-inpatient mental health services in its catchment area to priority populations as defined by DMHRH and DCYF. Additionally, the CMHCs have in place protocols to ensure cooperation and linkages with other public providers of mental health services statewide. CMHCs act in the role of a "gatekeeper" for all adult inpatient services.

Physician Supply and Distribution

As of January 1, 1998, 3,382 physicians were licensed to practice in Rhode Island. Approximately 70 percent of the state's total physician workforce is located in the Providence area. Physician practice sites are many and diverse, including hospital inpatient and outpatient departments, group and private practices, community health centers, federal facilities, as well as teaching and administrative positions in a variety of organizations.

Nationally, the physician/population ratio is 1 patient care physician for every 461 civilians. In Rhode Island the ratio is 1 per 363, placing the state 6th in the nation in ranking of physician supply. Population-per-physician ratios have been steadily decreasing over the past decade, suggesting that the growth in physician supply is outpacing the growth in the general population. This trend is evident nationally and in Rhode Island.

Rhode Island also has a higher percentage of general/family practice physicians and pediatricians than the rest of the United States. On the other hand, Rhode Island has a lower percentage of Ob/Gyns than the nation.

In evaluating primary care physician supply for a given population, the relevant numerator is the number of primary care physician FTEs who are engaged in *direct patient care activities*. The American Academy of Family Physicians recommends generalist physician to patient ratios of 1: 2,500, but suggests that as preventive health care and health promotion become more integral parts of future health systems, optimally-sized patient panels could shrink to as low as 1,300-2,000 per physician.

According to the licensure database maintained by the Rhode Island Department of Health the number of physicians in the primary care specialtiesis:

- Family Practice: 216
- Internal Medicine: 610
- Pediatrics: 258

There are 1,084 active primary care physicians in Rhode Island, or 40.0% of all active physicians, which equates to 1 primary care physician for every 1,094 people.

Community Health Centers (CHCs)

Since their inception about 30 years ago, Community Health Centers (CHCs) have delivered community-based primary care to medically underserved populations, including the uninsured. A major portion of the funding for CHC operations comes from two federal grant programs and the Medicaid and Medicare programs. The remaining portion derives from state and local governments, patient fees that are set on a sliding-scale basis according to income and family size, private insurance, and other contributions. Overall, grants tend to offset the difference between the actual costs of providing care and the amount collected from third-party payments and fees. These grants usually pay for the care of the uninsured and medically underserved, as well as essential support services (e.g., transportation, translation, outreach, case management) not covered by traditional insurers. These support services are intended to improve the health outcomes of this socially and economically stressed population.

With the recent closure of one health center, Rhode Island now has 13 health centers spread over 22 sites throughout the state (See Figure 54). Medical services provided by the centers include prenatal and obstetrical care,

family planning, gynecology, pediatrics, family medicine, adult internal medicine, optometry, podiatry, nutritional counseling, and dental care. In 1999, when there were 14 community health centers, primary care services were provided to 71,602 patients, 28,123 (39.3%) of whom were aged less than 19.

As states transition their Medicaid programs to managed care, CHCs find themselves either contracting or competing with managed care plans to serve Medicaid patients. With the advent of the RIte Care program, the network of private primary care providers willing to take care of Medicaid patients more than doubled. In response, Rhode Island's Health Centers banded together to create Neighborhood Health Plan of Rhode Island (NHP-RI), an HMO that contracts with RIteCare to help keep a critical mass of Medicaid-covered lives in the CHC system. (NHP-RI is one of 27 HMO-like plans in the country that are owned in whole or in part by Health Centers.)

Physician Assistants (PAs)/Nurse Practitioners (NPs)

There are approximately 149 Physician Assistants practicing in Rhode Island. PAs in Rhode Island are predominantly employed in single-specialty group practices (32 percent), hospitals (27 percent), and HMOs (21 percent). The percentages of Rhode Island PAs employed in group practices and HMOs are substantially higher than national averages. There are no PA training programs in Rhode Island. The two schools from which Rhode Island PAs have graduated most frequently are Northeastern University in Boston and Yale University in New Haven.

The licensure database maintained by the Rhode Island Department of Health indicates that in 1999 there were 353 NPs and 55 Certified Nurse Midwives in Rhode Island.

Nursing Supply

As of December 31, 1999, there were approximately 31,500 licensed nursing caregivers in Rhode Island, of which 16,662 (53%) were RNs, 2,998 (9%) were LPNs, and 38% were Nurses Aides (NAs). The total number of licensed nursing caregivers in Rhode Island has increased by 20% since 1992, when there were 26,185.

Physical Therapists

Allied health professionals are formally trained, licensed health care providers who practice in a variety of settings. They include psychologists, social workers, podiatrists, physical therapists, occupational therapists, speech therapists, and others. As of December 1999, there were 946 physical therapists practicing in Rhode Island. The number of licensed physical therapists in Rhode Island has increased by nearly 65% just over the past two years.

Currently there is only one accredited educational program for the physical therapy profession in the state of Rhode Island. The University of Rhode Island in Kingston offers a Professional Master s Degree Program. Although the number of graduates from all physical therapy programs is expected to continue to grow over the next several years, most programs only admit a very small percentage of applicants into the program. A lack of properly trained physical therapy faculty has forced most programs to put a cap on the number of students in each class.

Occupational Therapists

Occupational therapists provide rehabilitation services to individuals with physical, psychological, or developmental impairments. There are currently 531 occupational therapists employed in Rhode Island. The number of licensed occupational therapists in Rhode Island has increased significantly over the past decade; in just two years, the number has grown by 133%, from 227 in 1997.

Currently, most licensed occupational therapists in Rhode Island are employed by hospitals. The other settings in which occupational therapists practice include community mental health centers, schools for handicapped children, adult day care programs, outpatient clinics, rehabilitation facilities, nursing homes, sheltered workshops, and research facilities. However, no data exist currently regarding the number of occupational therapists in Rhode Island that practice in these settings. There are no occupational therapy programs in Rhode Island. Like physical therapy, occupational therapy is considered one of the fastest growing allied health professions. The increased demand for OT services is attributed to advances in medicine that allow physicians to save lives that may have previously been lost, such as children with birth defects and victims of accidents and disease; growth in the elderly population; and implementation of the federal 1975 Education for all Handicapped Children Law, which mandates special education programs for all handicapped children in the United States.

Speech Therapists

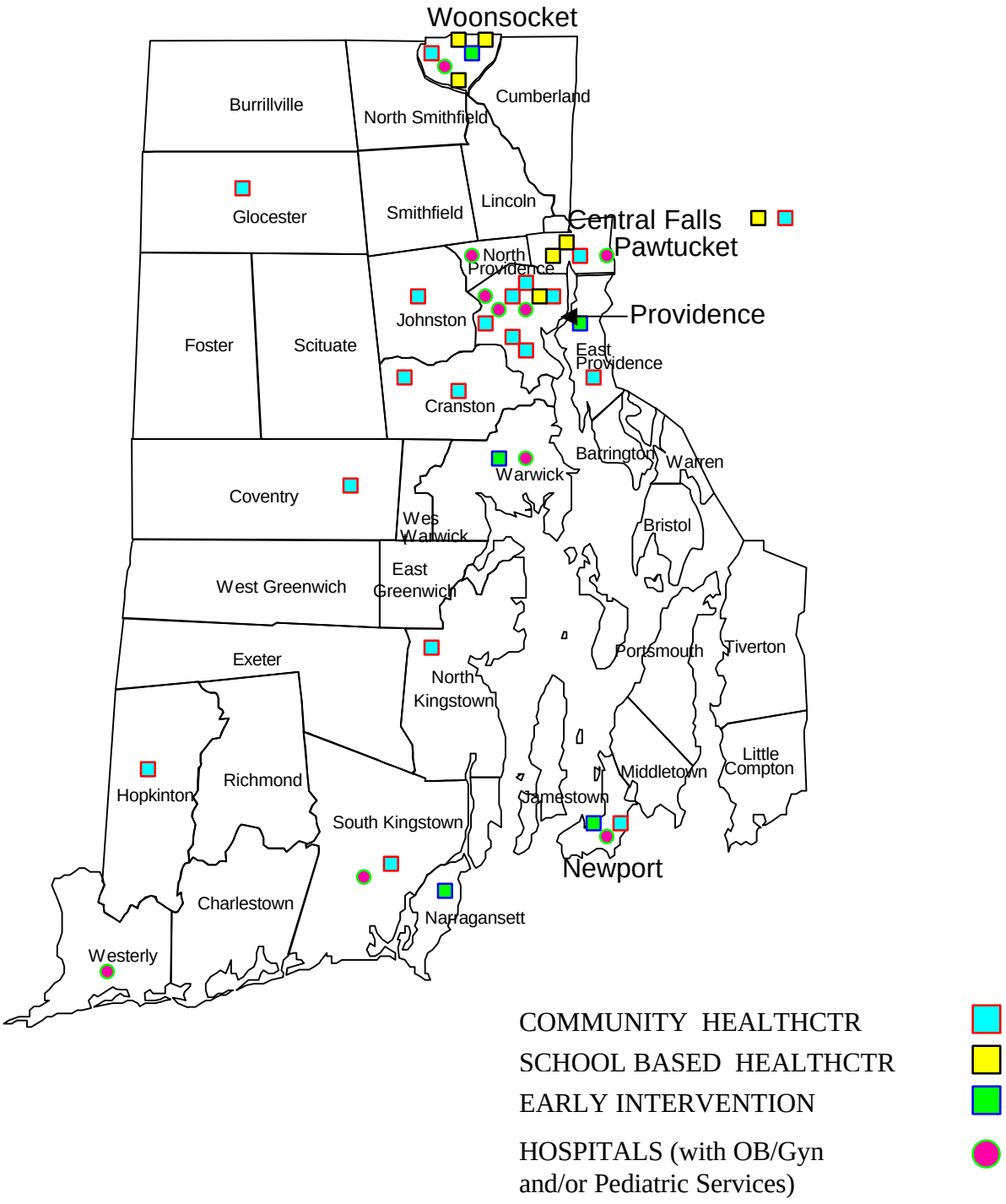
The number of speech-language pathologists and audiologists employed in Rhode Island has remained relatively stable. In 1999, there were 436 speech therapists and 41audiologists. Schools employ almost 60% of all practicing speech pathologists and audiologists in Rhode Island. The University of Rhode Island is the sole training institution in the state offering an accredited master's degree program as well as an undergraduate training program for speech-language pathology and audiology. Although the URI master's degree program enrolls no more than 50 students at any time regardless of demand for entry, the number of students completing the undergraduate program at URI has more than doubled in less than a decade. There has been a steady increase in the number of graduates from the URI speech pathology and audiology undergraduate and master's programs.

Hospitals

In Rhode Island there are fourteen hospitals and one inpatient treatment center licensed by the State of Rhode Island. Together these facilities comprise 3,928 beds, of which 700 were in a government- operated instiution primarily providing care for chronic disease patients, 165 were in psychiatric hospitals and 82 were in a dedicated rehabilitation facility. Of the 14 hospitals, 11 are community general hospitals and they report patient level data to the Department of Health. Nine of the community general hospitals provide obstetric/gynecologic and/or pediatric services. The location of these hospitals is shown on Figure 54.

Figure 54

Geographic Locaitons of Selected Health Care Providers
RHODE ISLAND, 2000



3.2 Health Status Indicators (see also Forms C1-C3 and D1-D3 in the Supporting Documents section)

3.2.1 Priority Needs (see also Table 68, Figure 55 and and Form 14)

Results from the statewide needs assessment, state and national performance measures, health status indicators, and community/stakeholder input provide a picture of the maternal and child health needs in Rhode Island. From this combination of quantiative and qualitative information, the state has identified thirteen priorities. Linked to each of these priorities is a state performance measure. Together the priorities represent each of the four levels of services (direct health, enabling, population-based, and infrastructure building) and all MCH population groups. Because the priorities often relate to more than one level of service, the service level assigned to the priority was determined by its performance measure. For example, the state performance measure selected to address the priority "reduce and manage pregnancy risks" has been determined to be an infrastructure building measure. Assuring systems are in place for pregnant women will hopefully lead to a reduction in pregnancy risk. Nevertheless, the measure, "percentage of pregnant women who receive prenatal care in the first trimester by population subgroups", could also be considered related to direct services, since programs such as the Women's Health Screening and Referral Program could impact this measure. There are similar instances where priorities and measures could relate to multiple levels of services.

Direct Health Services

The state has identified two priority areas which relate to direct services: "improve the health, safety and optimal development of adolescents" and "assure access to appropriate services during periods of transitions for CSHCN and other children". These priorities are derived from the needs assessment and health status indicators.

Rhode Island survey data and vital statisitcs indicate that teens are taking risks in the areas of tobacco, alcohol and drugs, sexual intercourse, and behaviors that may result in unintentional and intentional injuries.

The number of children enrolled in Early Intervention has been rising and nearly half of the children in EI go on to special education. The transition of these children into special education is critical.

Enabling Services

Two priority areas relate to enabling services: "improve the nutritional status of children, youth and their families" and "assure that eligible individuals participate in MCH programs through intensive outreach efforts". Childhood obesity continues to be a significant health risk among children in Rhode Island. One in five children enrolled in the Rhode Island WIC Program are overweight.

Not all those who are eligible for MCH programs are enrolled. Some families choose not to accept MCH services they are offered. Information from our Parents as Partners Program have shown that many families do not think they are eligible for programs such as WIC, RIte Care, etc. These programs can positively impact birth outcomes. Forty percent (40%) of Rhode Island newborns are determined to be at-risk for deveopmental delays. These newborns and their families are offered home visits, although some families do refuse these services.

Population-Based Services

Three priorities are population-based: provide education, support and environmental risk reduction to families;

strengthen partnerships between school, neighborhood and home; and increase community/family feedback/involvement regarding program services and policies.

Although the proportion of children in Rhode Island who have elevated lead levels (>10ug/dL) has been decreasing, still nearly one in ten children under age six have elevated lead levels. There are disparities among racial/ethnic groups and geographically.

Quality education is linked to adult success. High school dropouts are more likely to be unemployed, to be on public assistance, and to earn less money than high school graduates. In Rhode Island, 83% of students graduate high school--17% drop out. By strengthening partnerships between the school, neighborhood and home, long term improvements in the high school graduation rate may be achieved.

As stated earlier, community involvement and input is key to understanding the MCH needs and priorities of Rhode Islanders. As discussed, the Division of Family Health has strengthened its survey capacity and plans to continue getting direct feedback from families regarding its programs and services.

Infrastructure Building Services

Three priorities have been identified that are related to infrastructure building: assure the health, safety and optimal development of children in child care settings; expand access to genetic services during the preconception and prenatal periods; and reduce and manage pregnancy risks.

Studies have shown that quality child care programs are linked to school readiness. Children in these programs are cared for in environments that protect their health and safety and help them develop.

Ensuring access to genetic services and information, such as alpha-fetoprotein (AFP) screenings, genetic counseling, etc., can lead to a decrease in the number of children born with birth defects.

Other Priorities

In addition to the ten priorities described above, Rhode Island has identified three others including: improving access to non-medical support services for CSHCN and their families; assuring each child has a medical home that assures timely, comprehensive and coordinated preventive services and links to subspecialty services; and improving the quality, accessability and usability of information.

TABLE 68
State Identified Priority Needs FY 2001 – 2005

STATE PRIORITY NEED	POPULATIONS
1. Assure the health, safety, and optimal development of children In childcare settings.	(X) Pregnant women, mothers and infants (X) Children (X) CSHCN
2. Improve the health, safety, and optimal development of adolescents.	( ) Pregnant women, mothers and infants (X) Children (X) CSHCN
3. Expand access to genetics services during the preconception and prenatal periods.	(X) Pregnant women, mothers and infants ( ) Children (X) CSHCN
4. Reduce and manage pregnancy risks.	(X) Pregnant women, mothers and infants ( ) Children ( ) CSHCN
5. Provide education, support, and environmental risk reduction to families.	(X) Pregnant women, mothers and infants (X) Children (X) CSHCN
6. Strengthen partnerships between school, neighborhood, and home.	( ) Pregnant women, mothers and infants (X) Children (X) CSHCN
7. Assure access to appropriate services during periods of transition for children with special health care needs and other children.	( ) Pregnant women, mothers and infants ( ) Children (X) CSHCN
8. Improve the nutritional status of children, youth, and their families.	(X) Pregnant women, mothers and infants (X) Children (X) CSHCN
9. Assure that families participate in MCH program services through intensive outreach efforts.	(X) Pregnant women, mothers and infants (X) Children (X) CSHCN
10. Increase community and family feedback and involvement regarding MCH program services and policies.	(X) Pregnant women, mothers and infants (X) Children (X) CSHCN

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

Please refer to forms 2, 3, 4, and 5 in Supporting Documents Section 5.8.

3.3.2 Other Requirements

Title V expenditures for FY99 were $2,136,360, which represents an increase over the DFH's expenditures for FY98 of $445,066. During the last two years, the DFH has spent a significant amount of the carry forward to support its investments in home visiting, KIDSNET infrastructure, parent consultants and its communication activities. The DFH's expenditures for FY99 were allocated for preventive services for children (36%), children with special care needs (32%) and administrative costs (8%). In FY01, the DFH proposes to spend $1,886,635 including a carry forward of $139,459 from FY00. Although the DFH spent most of its carry forward from the prior year, the carry forward is a planned budgetary tool for dealing with unbudgeted expenses in future years and we intend to always maintain a reasonable carry forward. The DFH's FY01 budget allocates 37% to preventive services for children, 33% to children with special health care needs and 10% for administrative match. The DFH's

MCH budget for FY01 is $33,648,176, with $6,842,191 allocated from state resources not including program income and private funds. The FY00 budgeted figures are less than FY01 because additional state dollars were added to the Early Intervention program, Medicaid reimbursements and immunization payments increased and the DFH received an appropriation to manage Rhode Island's statewide poison control activities. The state match exceeds "the three-for-four" requirement for the expended FY99 funds and the proposed FY01 funds, including the carry forward. The maintenance of effort amount for FY99 and for proposed FY01 exceeds the FY89 level of effort of $1,875,000. Rhode Island defines administrative costs as those costs associated with disbursing funds from a central office (e.g., budgeting and oversight) that fall within the purview of administration. For the DFH, this includes the salaries of some of the personnel in the Medical Director's fiscal office.

The DFH expended $33,551,101 for maternal and child health services in FY 99, including $6,594,750 of state funds, an increase over our budgeted amount because of increases in the Early Intervention program and federal WIC and CDC immunization funds. The DFH has expended $4,355,821 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities. The DFH expended $5,671,092 on population based services, $2,312,466, on direct medical services and $520,446 on enabling services. For FY01, the DFH proposes to expend $4,471,614 on infrastructure, including an increased state investment in Early Intervention and school services and adolescent health and child care activities. Direct medical services equal $3,3031,045 mostly from the DFH's investment in Early Intervention services for children with special health care needs and $580,061 on enabling services from the DFH's Title V investments in outreach, home visiting and public education. The DFH proposes to expend $6,313,088 on population based services, an increase from prior years reflecting the transfer of newborn screening from the Laboratory to the DFH, follow-up home visits for at-risk newborns, women, children, and the DFH's KIDSNET pediatric tracking, management information system and lead poisoning prevention activities.

The DFH plans to allocate its FY01 award to meet the goals outlined in the annual plan by purchasing services from and contracting with other state agencies and community-based providers using standard purchasing procedures including RFPs, and sole/single source provider justifications. Every contract is managed by a program chief or manager, as well as monitored by DFH fiscal staff. Payment for services outlined in the contract is reviewed and approved by the contract officer and the division administrator prior to reimbursement**.**

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

3.4.1.1 Five Year Performance Measures

See Figure 55 (Figure 4 in Guidance) on page 153. See Form 11 for 5-year targets in Supporting Documents Section 5.8.

3.4.2 **State "Negotiated" Five Year Performance Measures**

3.4.2.1 Development of State Performance Measures

Rhode Island developed 10 performance measures, which are listed in Table 68 on page 150 and described in detail on Form 16 in Supporting Documents Section 5.8. These measures represent all four levels of the pyramid.

3.4.2.2 **Discussion of State Performance Measures**

Tables 68 on page 150 & 69 on page 156 show the relationship of Rhode Island's 10 performance measures with the DFH's identified Priorities Form 16 provides the definition of these measures along with their significance. Each of the 10 measures are linked directly to Rhode Island's 10 top priorities. Program managers worked in conjunction with data staff in order to determine these measures, which were selected using a variety of criteria, including data availability, measurement of priority, and proxy for other measures. Additionally, measures were determined to ensure that there was at least one measure in each of the four levels of the pyramid. Of the 10 state performance measures developed, two are related to direct services, two are related to enabling services, three are related to population-based services, and three are related to infrastructure building. The majority are linked or related to the six outcome measures. For instance, state performance measure #4 address the priority of reducing and managing pregnancy risks and measures the proportion of pregnant women who received prenatal care in the first trimester by special population groups. This measure is related to infant mortality and outcome measures 1-5.

3.4.2.3 Five Year Performance Objectives (See Form 11 in Supporting Documents Section 5.8).

3.4.2.4 Review of State Performance Measures (No materials included)

3.4.3 Outcome Measures

See Forms 12, 11 &16 in Supporting Documents Sections 5.8 & 5.10 . Rationales and priority relationships of State measures are on page 156.

See Figure 56 (Figure 3 in Guidance) on page 155.

Figure 55
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	**ES**	**PBS**	**IB**	C	**P**	**RF**
1) Percent of children in child care, aged 18 months or older, who are up to date on their immunizations				**X**			**X**
2) Percent of students in schools with health centers who are enrolled in the school-based health centers	**X**					**X**	
3) Proportion of pregnant women who receive an alpha-fetoprotein screening test				X		X	
4) Percent of pregnant women in at-risk population subgroups who receive prenatal care in the first trimester				X			X
5) Percent of children aged less than 6 in at-risk population subgroups tested with lead levels $\geq$10ug/dL			**X**				X
6) Percent of ninth-graders who are expected to graduate from high school (based on the existing drop-out incidence among 9^{th}, 10^{th}, 11^{th} and 12^{th} graders)			**X**				X
7) Number of children in the Early Intervention Program with Integrated Family Service Plans (IFSPs) for whom an Individual Education Plan (IEP) is developed	X					X	
8) Percent of infants and children in the WIC Program who are overweight (high weight for stature) or underweight (low weight for stature)		X					X
9) Percent of at-risk newborns who receive a home visit from the Family Outreach Program during the early newborn period		X				X	
10) Number of completed family surveys			X			X	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Figure 56

TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM

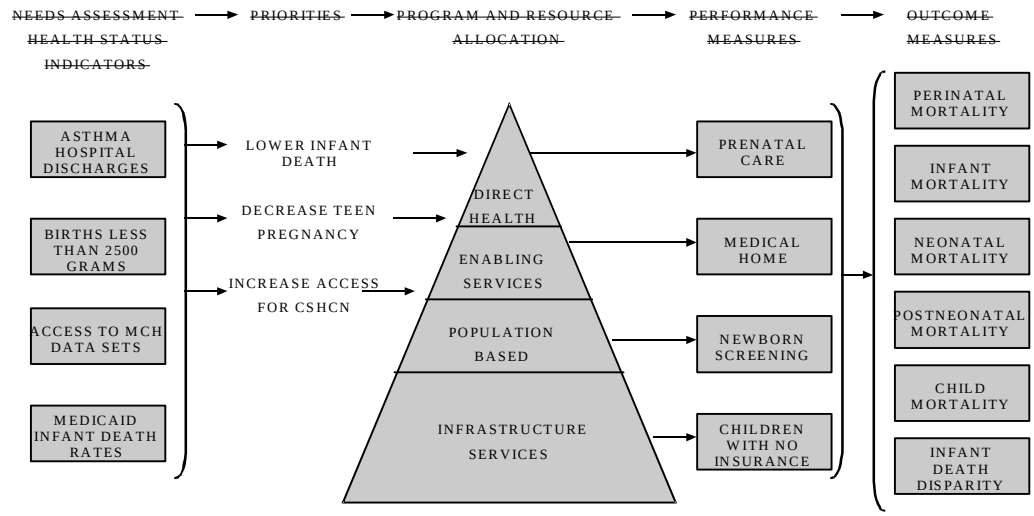


TABLE 69
Five-Year State Performance Measures 2001 - 2005

SPM #	Rationale	Related to State Priority Need #	Level of Pyramid	Related to Outcome #
1	Assuring children in child care receive immunizations will contribute to their health, safety, and optimal development.	1	I	6
2	Increasing the number of adolescents enrolled in school-based health centers (SBHCS) will help ensure that their access to health services and ultimately improve their health, safety, and optimal development.	2	D	6
3	Access to genetic services, including testing and counseling, is key in reducing the occurrence of birth defects and poor birth outcomes. AFP screening is one measure of genetic service access.	3	I	1-6
4	Adequate prenatal care reduces the likelihood of poor birth outcomes, including low birthweight and infant mortality. Although a high proportion of Rhode Island women receive prenatal care in the first trimester, there are disparities among racial and ethnic groups and geographically.	4	I	1-5
5	Although the proportion of children with lead levels $\geq$ 10 ug/dl has been declining, nearly one in ten children have elevated lead levels. There are disparities among racial and ethnic groups and geographically.	5	P	1-6
6	Education is linked to success. High school dropouts are more likely to be unemployed, to be on public assistance, etc. By strengthening partnerships between the school, neighborhood and home, long-term improvements in the high school graduation rate may be achieved.	6	P	6
7	Assuring that children transitioning out of Early Intervention have an Individual Education Plan (IEP) helps to ensure their access to special education services and that their needs will be met.	7	D	
8	Improving the nutritional status of children, including those with conditions such as "failure to thrive", may ultimately prevent infant and child deaths.	8	E	1-6
9	Not all those who are eligible for MCH programs participate. Home visits are offered to families with newborns determined to be at risk for developmental delays. These newborns are referred to appropriate community-based services.	9	E	1-5
10	Parent involvement in program services and policies can ultimately improve programs and their ability to reach more families with appropriate services.	10	P	1-6

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

NPM #1 –The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Population(s): ( ) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 70
New or Continuing Programs/Activities
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **SSI Team**: The DFH will continue to support the activities of the statewide SSI Team, which was created in 1994 following the Supreme Court decision, Zebly, to provide a safety net for children eligible for SSI & their families.	I	During 2001, the SSI team will engage other stakeholders (i.e. hospital sites, Early Intervention programs, the Rhode Island Department of Human Services (DHS), Head Start, and schools to identify target groups within their systems and educate them regarding the SSI application process. A team of parents and professionals will provide technical assistance and guidance to these groups.
2. **CSHCN Program**: The DFH will continue to work closely with the community-based advocacy group Family Voices to advocate on behalf of CSHCN on SSI, including those in need of rehabilitative services.	P	Due to successful outreach efforts, the demand for information, education, and support for families with CSHCN has increased. Family Voices will work with the DFH & the Rhode Island Parent Information Network (RIPIN) to develop and implement a "Train the Trainers" initiative, the purpose of which will be to inform families and professionals about the SSI application and appeals process. The DFH's MCH Hotline staff will work closely with RIPIN to refer families who call the Hotline to appropriate services.
3. **Genetics Program**: The DFH's Core Genetics Group will continue to work on developing an infrastructure designed to meet the challenges of recent rapid advances in genetics.	I	The DFH will work to develop a birth defects registry, utilizing available data. Since R.I. has small numbers of children with birth defects, the DFH will explore the feasibility of pooling resources with the New England states to create a regional database for surveillance. On the state level, children, ages 0-5, who are eligible for SSI and their families will be identified through the DFH's KIDSNET system and linked to appropriate resources to help them with the SSI application process.
4. **Early Intervention (EI) Program**: The DFH will continue to fund a community-based regional network to provide early intervention services to CSHCN, ages birth to 3, including those receiving SSI.	I	In order to respond to an increase in demand for early intervention services, the DFH will establish new certification standards for EI providers and increase existing service capacity. EI parent-consultants will continue to assist families with service planning and implementation. The DFH will complete the process dedicated to revising and updating its EI regional and statewide data systems in 2001. In addition, the DFH will develop a public engagement campaign to reposition the EI Program and to increase public awareness of child growth and development.
5. **Disabilities & Health Program**: The DFH will work closely with the state Department of Human Services (DHS) to develop the planned		DHS is using results from the DFH's 1999 survey assessing access and quality of primary and specialty services for CSHCN receiving Medicaid, SSI, or

CEDARR initiative		foster care services to help shape CEDARR. The role of DFH parent-consultants and staff in the design will be important. The implementation of CEDARR is planned for 2001. CEDARR will serve to increase this population's access to service coordination and rehabilitative services through the establishment of "centers of excellence" for CSHCN throughout the state.
6. **Child Development Center (CDC):** The DFH will continue to support the CDC to provide specialty and sub-specialty services for medically complex CSHCN, birth to 21.	I	The DFH has included a stronger quality assurance component in its contract with the CDC, which will work to assure that children receiving services through the CDC are linked to appropriate rehabilitative services. Also, DHS's planned CEDARR initiative will serve to increase this population's access to rehabilitative services.
7. **Parent-Consultant Program**: The DFH will continue to support paid parent consultants to assist the DFH with CSHCN program development and implementation.	E	DFH parent consultants will continue to be members of the DFH's SSI Team and Core Genetics Group and will continue to address the rehabilitative needs of CSHCN receiving SSI through the DFH's EI Program, Disabilities & Health, CSHCN Services and the CDC.
8. **Traumatic Brain Injury (TBI) Program:** The DFH will continue to support a statewide TBI/SCI surveillance system based on hospital discharge data.	I	In response to a 1997 legislative mandate, the DFH is preparing regulations that will establish reporting requirements for spinal cord injuries. The DFH anticipates that the regulations will be issued in 2001.

TABLE 71
Programs/Activities to Be Reviewed or Revised
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
8. **Traumatic Brain Injury (TBI) Program**: The TBI Program will be referred to as the Traumatic Brain & Spinal Cord Injury (TBSCI) Program in the DFH's future Title V applications.	I	

Use * for new program (<1 yr old)

NPM #2 – The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Population(s): (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 72
New or Continuing Programs/Activities
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Early Intervention (EI) Program**: The DFH will continue to support a statewide community-based regional system of early intervention agencies to provide specialty and subspecialty services, including care coordination, to CSHCN ages birth to 3.	I	In order to respond to an increase in demand for early intervention services, the DFH will develop and implement new certification standards for EI providers and increase existing service capacity. Assuring family-centered care and family-to-family support is difficult in a cost contained managed care environment. The state's planned CEDARR initiative will impact CSHCN in EI.
2. **CSHCN Program**: The DFH will continue	I	The EI Program is a major link to assure that families

to advocate for specialty and subspecialty services, including care coordination, for CSHCN on the state level.		have accessibility to specialty and subspecialty services in R.I. The DFH's efforts to assure a commercial mandate for care coordination and other services have fallen short and needs to be advocated for with more organized parent leadership. DHS's CEDARR Initiative will impact all services for CSHCN in the state. The DFH's MCH Hotline will be enhanced so as to be better able to link families with existing services and parent organizations.
3. **Child Development Center (CDC)**: The DFH will continue to support the CDC to provide specialty and subspecialty services, including care coordination, to medically complex CSHCN ages birth through 21.	I	The DFH has included a stronger quality assurance component in its contract with the CDC, which will work to assure that children receiving services through the CDC receive all of the services they need. DHS's CEDARR Initiative will impact CDC services as well.
4. **Groden Center**: The DFH will continue to support the Groden Center to provide services to infant and toddler CSHCN with an identified mental/behavioral health concern.	I	With the increasing identification of behavioral health issues, a stronger link with specialty clinics for statewide services will be addressed by the DFH. The state's community mental health centers, the Groden Center, Bradley Hospital, and others in the field will be assessed regarding needs and future direction. DHS's CEDARR initiative will include a mental/behavioral health component.
5. **Rhode Island Hearing & Assessment Program (RIHAP):** The DFH will continue to support the RIHAP to provide education, training, intervention and support (including care coordination) to families with children who have been identified as deaf or hard of hearing.	I	During this period, the DFH will continue to utilize the HRSA infrastructure grant to support the Rhode Island Hearing & Assessment Program (RIHAP). DHS's CEDARR Initiative will impact services provided to this population by providing "centers of excellence" for all CSHCN, including those who are deaf or hard of hearing.
6. **Disabilities & Health Program**: The DFH will continue to support population-based activities that are designed to promote the health and wellness of individuals with disabilities, including CSHCN.	P	The DFH will continue to provide on-going training for providers on a variety of disabilities & health topics, including access to assistive technologies.

TABLE 73
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
NPM #2: There are no activities needing revision at this time.		

Use * for new program (<1 yr old)

NPM #3 – The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"

Population(s): (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 74
New or Continuing Programs/Activities
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Early Intervention (EI) Program**: The DFH will continue to support a community-	I	The DFH will develop and implement new certification standards for EI providers and increase

based statewide system to assure that CSHCN, ages birth to 3, have a "medical home".		existing service capacity, which will strengthen assurances that each child has a "medical home". EI Program service coordinators will continue to facilitate and assure access to primary health care services for this population. DHS's planned CEDARR Initiative will strengthen the state's existing system for assuring that CSHCN have a "medical home".
2. **CSHCN Program**: The DFH will work to assure that children with asthma have a "medical home".	I	The DFH collaborates with HEALTH's Division of Disease Control & Prevention Program to implement the activities outlined in HEALTH's Childhood Asthma Prevention & Control grant. The DFH will utilize 2001 to finalize preparation of two papers for publication, prepare a childhood asthma module for HEALTH's Rhode Island Interview Survey, and conduct a childhood asthma survey to e completed by school nurse teachers and primary care providers throughout the state, and design a system to evaluate childhood asthma outcomes.
3. **Child Development Center (CDC**): All children receiving services through the CDC have a "medical home".	I	The DFH has included a stronger quality assurance component in its contract with the CDC, which will work to assure that children receiving services through the CDC have a "medical home". Also, the state's planned CEDARR initiative will impact CDC services.
4. **Home Visiting Program**: The Home Visiting Program will continue to assure that CSHCN, birth to 6, have a "medical home".	I	Home Visitors will continue to provide culturally competent family support, outreach, referral, education and assistance with health insurance and other health care needs. CSHCN will be referred to the state's Early Intervention Program or the Rhode Island Department of Education (RIDE), depending on their age. Though this process, the DFH will continue to assure that each child is linked with a primary care provider (i.e. "medical home").
5. **Healthy Tomorrows Project**: Through this pilot, the DFH will assure that children (including CSHCN) in foster care have a "medical home".	I	DFH Home Visitors will continue to assure that primary care providers have up-to-date health information about foster children in their care. The pilot will become a permanent part of the state's system of care for foster children, through the state Department of Children, Youth & Families (DCYF), in 2001.
6. **KIDSNET**: The DFH will enroll all pediatric providers in KIDSNET to assure that all children, including CSHCN, are identified and linked to a primary care provider and appropriate support services.	I	The DFH will enroll all pediatric providers into KIDSNET in 2001.
7. **Disabilities & Health Program**: The DFH will continue to produce and disseminate an annual Disabilities Data Book to provide a basis for developing effective interventions for individuals with disabilities, including CSHCN.	E	The first version of this book was produced in 2000, and it was disseminated across the state to community-based agencies and state policymakers. The DFH will update the book on an annual basis.
8. **"Parents As Partners" SSDI Initiative**: This systems development initiative will continue to assure that families with children,	I	The DFH will utilize 2001 to expand the model in Providence. The DFH will work closely with the 60-member Mayor's Task Force on Early Childhood to

including CSHCN, are assisted with establishing a "medical home" for their child's care.		develop strategies to improve the system of services for families with young children in Providence. Addressing the barriers and needs of Providence's minority families will be a focal point of the Providence SSDI Initiative. 1n 1999, 81% of Providence's school children were minorities and 48% were of Latino descent. Currently, the Task Force is developing a plan that may include training and supporting culturally diverse "peer parents" who would help families navigate the service system in Providence. Challenges will include securing adequate sources of funding for infrastructure building and programmatic support.
9. **Newborn Screening Program**: The DFH will continue to support this initiative, which identifies developmental delay through a Level I screening process.	I	Infants identified to be at risk will continue to receive culturally competent home visiting services through the DFH's Home Visiting Program.
10. **Lead Case Management Services**: The DFH will continue to support a Lead Center to assure a "medical home" and provide comprehensive care for significantly lead poisoned children (Pb = $\geq$ 20 ug/dl) under 6 years of age.	I	The Lead Center provides significantly lead poisoned children with a "medical home" by providing a comprehensive array of culturally competent services, including home visiting, parent education, screening for developmental delay, linkage to nutrition services, and referrals for an environmental inspection. The Lead Center also provides each child's primary care provider with status reports on an ongoing basis. In addition, the DFH's Home Visiting Program provides education and support servcies to the families of children with elevated lead levels throughout the state.
11. **Child Opportunity Zone (COZ)/Starting Points Initiatives**: The DFH will continue to support Child Opportunity Zone (COZ) Family Centers that link families with CSHCN to Medicaid, SSI, and a "medical home".	I	The DFH will continue to support the state's 13 school-linked Child Opportunity Zone (COZ) Family Centers with Title V funds for activities related to the COZs' infrastructure and operations. In addition, the DFH will continue to support the development and implementation of early childhood programs administered by 9 of the COZ Family Centers, utilizing funding from the Carnegie Corporation (Starting Points).
12. **School-Based Health Center (SBHC) Program:** The DFH will continue to support SBHCs in urban communities to provide comprehensive medical and mental/behavioral health services to adolescents.	I	SBHCs are the "medical home" for many adolescents living in racially/ethnically diverse urban communities in R.I.

TABLE 75
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
2. **CSHCN Program**: The DFH's involvement with HEALTH's Asthma Prevention and Control grant is a new activity less than a year old.	I	
5. **Healthy Tomorrows Project**: This project will become a permanent part of the state's infrastructure in 2001.	I	As a result, the DFH will not include this initiative in its future Title V applications.

Use * for new program (<1 yr old)

NPM #4 –Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (i.e., the sickle cell diseases) (combined).

Population(s): (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 76
New or Continuing Programs/Activities
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Women's Health Screening & Referral Program (WHSRP):** The DFH will continue to support no cost pregnancy testing and health risk assessment & referral for women with a suspected pregnancy.	I	Although the DFH provides direct services through WHSRP, it will utilize FY2001 to address identified gaps in the system of care for women. In 1999, the WHSRP determined that uninsured women with negative pregnancy test results have limited access to genetics services. The DFH will utilize 2001 to address this gap in the system of care for women.
2. **Metabolic Screening Program**: The DFH will continue to assure that all newborns are screened for metabolic conditions.	I	The DFH will integrate this program into KIDSNET in 2001. The DFH, through an advisory committee process, will develop criteria for adding or changing conditions in the Metabolic Screening Program.
3. **KIDSNET**: The DFH will provide primary care providers with immediate metabolic screening results (both positives and negatives) for their pediatric patients through KIDSNET.	I	Integration with KIDSNET will assure that tracking, timely screening and repeat screening, and home visiting contacts are coordinated. KIDSNET will initiate follow-up rather than the state laboratory.
4. **Genetics Program**: The DFH's Genetics Team will continue to work with KIDS NET to develop a system to assure linkages with appropriate follow-up services for CSHCN with identified metabolic conditions.	I	The DFH will work with prenatal care units in the state to develop linkages between obstetrical servcies and pediatricians to assure that pregnant women have a pediatrician prior to delivery. Also, the OB/GYN clinics will be assessed regarding their informing clients of all newborn screening activities.
5. **Home Visiting Program**: The DFH will continue to provide home visiting services to at risk families and children with identified metabolic conditions.	I	KIDSNET will continue to be utilized to refer at risk pregnant women and newborns for home visiting services.
6. **"Parents As Partners" SSDI Initiative**: The DFH will continue to support community-driven strategic planning to increase utilization of MCH services, including follow-up and support for families with children with identified metabolic conditions.	I	The DFH will include home visiting activities as a part of its efforts to expand the "Parents As Partners" model to Providence. The DFH will work closely with the Mayor's Task Force on Early Childhood to implement this initiative in 2001.

TABLE 77
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
NPM #4: There are no activities needing revision at this time.		

Use * for new program (<1 yr old)

NPM #5 –Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B

Population(s): ( ) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

TABLE 78
New or Continuing Programs/Activities
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Immunization Program**: The DFH will continue to provide vaccine to all providers, free immunization services for uninsured children, and immunization education to providers and the general public.	I	U.S. Centers for Disease Control (CDC) funding to R.I. for immunizations has been cut by 60%. Vaccine "switches" and a new vaccine will increase costs significantly. The DFH will increase insurance assessment fees to cover expected program costs in 2001. The DFH will continue to support 2 hospital-based clinics to provide free immunizations to uninsured children in inner city Providence. In addition, the DFH will continue to support the annual "Big Shots For Little Tots" health fair in Providence, in conjunction with the RI Chapter of Jaycees, the RI Chapter of Rotary Club International, and Providence Community Health Centers.
2. **KIDSNET**: The DFH will create a statewide immunization registry for all children, including CSHCN, living in Rhode Island.	I	The DFH plans to enroll all primary care providers in the state into KIDSNET by the end of 2000, with complete immunization histories for all children born as of 1/1/97. By doing so, the DFH will be able to track immunization compliance for the DFH's targeted population of children living in Rhode Island. The DFH's Immunization Program will work with the U.S. Centers for Disease Control (CDC) and KIDSNET to develop a comprehensive quality improvement program for all enrolled providers, encompassing assessment, feedback, and vaccine accountability. KIDSNET will also assure that the Immunization Program has racial and ethnic data for this population.
3. **Newborn Screening Program**: The DFH will continue to send Hallmark congratulations cards, which include information about the importance of timely immunizations, to all families with newborns.	I	The DFH will continue to use the KIDSNET database to conduct this ongoing activity.
3. **Home Visiting Program:** The DFH's Home Visiting Program will continue to include an educational component to assure that families are informed about the importance of immunizations and bring children who are behind on their immunizations up-to-date.	I	Children who are behind on their immunizations are identified through KIDSNET.
4. **Immunization Media Campaign**: The DFH will continue to conduct public education, outreach and promotion activities related to childhood immunization.	P	The DFH and the statewide Immunization Action Coalition will collaborate in a targeted effort to reduce "missed opportunities" through the creation of opportunities for immunization.
5. **Healthy Child Care**: The DFH will continue to support activities to assure that parents with children in child care and child	E	The DFH will distribute information and resource materials through direct mailings, a newsletter, and a resource library; conduct parent education and

care providers have access to information about the importance of childhood immunizations.		provider training through the Child Care Support Network (CCSN); and link with the American Academy of Pediatrics to leverage resources around promoting immunizations for young children. The DFH anticipates that the number of childcare providers through the CCSN will increase from 150 to 250 in 2001. The DFH will also increase parent outreach and education opportunities in child care settings through increased collaboration with the DFH's Parent consultant Program.
6. **WIC Program**: The DFH will assure that children who are enrolled in WIC are brought up-to-date on their immunizations.	I	The DFH plans to transmit information on children who are behind on their immunizations from KIDSNET to the WIC database. WIC will then transmit this information to local WIC programs located throughout the state. The DFH will provide training for local WIC staff to assure that they convey effective messages to the parents of children who are behind on their immunizations. WIC staff will assist targeted children to become up-to-date.
7. **"Parents As Partners" SSDI Initiative**: The DFH will continue to support community-driven strategic planning to increase utilization of MCH services, including childhood immunization.	I	The DFH will include childhood immunization activities as a part of its efforts to expand the "Parents As Partners" model to Providence. The DFH will work closely with the Mayor's Task Force on Early Childhood to implement this initiative in 2001.
8. **Child Opportunity Zone (COZ)/Starting Points Initiatives:** The DFH will continue to supported school-linked COZ Family Centers to educate families with young children about the importance of timely immunizations.	I	COZ Family Centers will also continue to assist families in establishing a 'medical home" through outreach and referral to RIte Care and other culturally appropriate community-based services, including the DFH's Home Visiting Program.
9. **Parent-Consultant Program**: The DFH will continue to support a paid parent consultant in the Immunization Program.	E	The parent consultant will continue to participate in health fairs and educational seminars in communities, schools, churches, and health centers.

TABLE 79
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
NPM #5: There are no activities needing revision at this time.		

Use * for new program (<1 yr old)

NPM #6 – The birth rate (per 1,000) for teenagers aged 15 through 17 years.

Population(s): ( ) Pregnant Women, Mothers and Infants (X) Children (Adolescents) (X) CSHCN

TABLE 80
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **School-Based Health Center (SBHC) Program**: The DFH will continue to support SBHCs to provide comprehensive health and mental health servcies to adolescents.	I	Rhode Island does not have stable funding for SBHCs. The DFH will continue to use Robert Wood Johnson (RWJ) Foundation funds through March 2001 to support the efforts of a newly formed Rhode Island Assembly on School-Based Health Care. The Assembly will advocate

		for the expansion of SBHCs and develop state policy for long term sustainability. During FY2001, the DFH will seek legislative support, expand partners to support, expand Medicaid support, and expand into urban high schools. The basic risk-screening program will continue and the DFH will seek Rhode Island Department of Human Services (DHS) and/or U.S. Centers for Disease Control (CDC) funding to continue.
2. **Family Planning Program**: The DFH will continue to support 11 family planning clinics located throughout the state to provide no cost and low cost confidential family planning services to adolescents.	I	Federal Title X and state "family life" funds will support local clinics to provide direct family planning services to adolescents seeking confidential services. In October 1999, one of the clinics closed. The DFH will add Planned Parenthood of Rhode Island's Teen Clinic as an additional site in 2001. The DFH will look to the DHS for Medicaid match funds for the Women's Health Screening & Referral Program (WHSRP) to free up state funds for additional family planning sites. In addition, the DFH may receive additional Title X funds to expand sites and client utilization. The DFH will also utilize 2001 to develop and produce new culturally and linguistically appropriate printed family planning informational materials for teens.
3. **Women's Health Screening & Referral Program (WHSRP):** The DFH will continue to provide no cost pregnancy testing and health risk assessment and referral for women requesting a pregnancy test, including adolescents, in the DFH's 11 family planning clinics.	I	A pilot project for at risk adolescent girls and those with negative pregnancy tests will continue to be administered through the Cranston Community Action Program, which serves teens in Cranston and Coventry. About 50 girls will receive a personal coach & advocate along with case management, referrals for family planning, and youth development activities such as community service projects, health education, career exploration, and workshops for parents. During 2001, the DFH will seek additional foundation support for continuing the project.
4. **Men 2 B Program**: The DFH will continue to fund these projects, which focuses on training men to be effective role models to boys.	E	Men 2 B will continue to provide training and support to men in four urban communities, preparing them to be effective role models for boys and to communicate messages about abstinence from sexual intercourse, substance use, and violence.
5. **Fathers & Family Network**: The DFH will continue to participate in the community-based network designed to bring together all parties interested in supporting fathers and fatherhood.	E	The DFH will continue to support the Network advocate for the needs of fathers and support policies and programs, which strengthen responsible fatherhood.
6. **Adolescent Media Campaign:** The DFH will implement a statewide public media campaign designed to project positive images of youth, promote youth development, empower adults to build meaningful relationships with teens, provide appropriate discipline and set boundaries for youth.	P	The campaign kick-off is planned for January 2001, and the campaign will run at various times throughout the year. The DFH is actively seeking funding partners for this effort.
7. **Youth Care Health Education Projects**: The DFH will continue to fund health education and youth development programs in 4 after-school programs.	I	The DFH will continue to fund 4 pilot health education initiatives in Providence, Warren, and Newport, dealing with sexuality, physical fitness, and nutrition.
8. **Healthy Schools/Healthy Kids**: The DFH will continue to work with Department of	I	DFH staff will continue to participate on the Healthy Schools/Healthy Kids Steering committee and work

Education partners on the Healthy Schools/Healthy Kids Coalition to build a strong statewide infrastructure for comprehensive school health programs.		groups to help implement school initiatives that improve student health and meet student developmental needs.
9. **The Rhode Island Children's Cabinet**: DFH staff will continue to co-convene the Children's Cabinet Youth Success Cluster.	I	The Youth Success Cluster provides technical assistance, technical support, and policy development to communities implementing comprehensive and coordinated youth services programs.
10. **Home Visiting Program**: The Home Visiting Program will continue to provide family planning and birth control education to teens who receive home visits.	I	Pregnant and parenting teens are sometimes referred to the Home Visiting Program. Others receive home visits through the Department of Human Services (DHS) adolescent self-sufficiency programs.
11. **Parent Consultant Program**: The DFH's Adolescent and Young Adult (AYA) Unit intends to support its current parent-consultant until the end of 2000.	E	The parent-consultant has been a valuable member of the AYA Unit, providing input from a young adult male perspective.

TABLE 81
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
7. **Youth Care Health Education Projects (*)**: Created in 2000, this new initiative is less than a year old.	I	This pilot builds on the state's Starting Right initiative, by providing funds to help childcare providers develop and implement a quality health education component in 4 after school programs for youth.
11. **Parent Consultant Program:** The DFH will develop new ways to obtain teen and parent input.	E	Beginning in 2000, the DFH will expand its relationships with teens through a contract with the Youth In Action organization, which is run by youth involved in community service work in Providence. The DFH will also solicit more input from parents of teens. As a consequence, this initiative will be referred to as "Youth Input" in the DFH's future Title V applications.

Use * for new program (<1 yr old)

NPM #7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Population(s): ( ) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

TABLE 82
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Oral Health Coordinating Team:** The DFH will continue to be a member of the Rhode Island Department of Health's Oral Health Coordinating Team.	I	There is an ongoing and increasing shortfall in oral health services for children, especially low-income children and CSHCN, who often have deferred dental problems. HEALTH's Oral Health Coordinating Team is charged with developing recommendations to improve the oral health of school-aged children, including CSHCN. The DFH will also work closely with the state Department of Human Services as it proceeds with its plans to restructure the oral health service delivery system for children receiving Medicaid. Specifically, the DFH will continue to

		advocate for adequate reimbursement for dental care (including dental sealants), particularly in school-based and school-linked settings.
2. **Disabilities & Health Program**: The DFH will continue to provide free oral health screenings at the Special Olympics during the summer.	E	A dozen dentists and dental hygienists volunteered their time with a goal of screening 300-500 adults and children. Parents were also provided with a list of local dentists who provide dental care to CSHCN and accept Medicaid as a source of payment. The screening will provide data for the U.S. Centers for Disease Control (CDC) to help improve dental access for individuals with disabilities, including CSHCN. The DFH's Disabilities & Health parent consultant is the co-coordinator of this event.
3. **Home Visiting Program**: Young children who receive home visits will continue to be assessed for "baby-bottle tooth decay" and their parents will continue to be provided with information about the importance of routine preventive dental care.	E	Children will continue to be referred to the Home Visiting Program through KIDSNET.
4. **WIC Program**: The DFH will continue to assure that families of children who are enrolled in WIC have access to information about "baby bottle tooth decay" the importance of routine preventive dental care	E	Families receiving WIC services will continue to receive ongoing information about these topics. WIC staff will continue to utilize a risk assessment to make referrals to dental and other appropriate health care providers.
5. **Healthy Child Care**: The DFH will continue to support activities to assure that parents with children in child care and child care providers have access to information about the importance of preventive dental care.	E	The DFH will continue to support tote bags to lend to parents on a variety of topics, including the importance of preventive dental care, through the Child Care Support Network (CCSN). The DFH will also continue supporting dental care resource materials to the child care community through the state's childcare training agency (CHILDSPAN). CHILDSPAN reaches about 3,000 parents and childcare providers each year. The DFH will also increase parent outreach & education opportunities through increased collaboration with the DFH's Parent Consultant Program.

TABLE 83
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
2. **Disabilities & Health Program (*)**: The DFH provided free oral health screenings at the Summer Special Olympics for the first time in June 2000.	I	The DFH will work to make this initiative a permanent part of the annual Special Olympics.

Use * for new program (<1 yr old)

NPM #8 – The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Population(s): ( ) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

TABLE 84
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Home Visiting Program**: The Home Visiting Program will continue to provide auto safety information to families who receive home visits and refer for free care seats, as appropriate.	E	Low-income families receiving home visiting services through the DFH's Home Visiting Program will continue to be linked with the Rhode Island Safe Kids Coalition that, among other things, provides free car seats and auto safety education.
2. **Early Intervention (EI) Program**: The Meeting Street EI Center will continue to provide training on the special care seat needs of CSHCN to other regional staff on an as needed basis.	I	In addition, the DFH, in conjunction with HEALTH's Injury Prevention Program, will apply to the U.S. Centers for Disease Control (CDC) for funds to strengthen its statewide care seat safety program, which will include the special care seat safety needs of CSHCN.
3. **Healthy Child Care**: The DFH will continue to support activities to assure that parents with children in child care and child care providers have access to information about car seat safety.	I	The DFH will continue to support tote bags to lend to parents on a variety of topics, including the proper use of child car seats, air bag safety, and the backseat as being the safest location for children through the Child Care Support Network. The DFH will also continue supporting auto safety training and resource materials to the child care community through the state's childcare training agency (CHILDSPAN). The DFH will also increase parent outreach & education opportunities through increased collaboration with the DFH's Parent Consultant Program.
4. **Women's Health Screening & Referral Program (WHSRP):** The WHSRP will continue to assess pregnant and non-pregnant women for substance abuse risks and refer them to treatment services, as appropriate.	I	Unfortunately, low-income, uninsured women's access to substance abuse services is limited in R.I. The DFH plans to address this gap in the system of care for women in 2001, in partnership with the Department of Mental Health, Retardation & Hospitals (MHRH), Division of Substance Abuse.

TABLE 85
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
NPM #8: There are no activities needing revision at this time.		

Use * for new program (<1 yr old)

NPM #9 – Percentage of mothers who breastfeed their infants at hospital discharge.

Population(s): (X) Pregnant Women, Mothers and Infants ( ) Children ( ) CSHCN

TABLE 86
Programs/Activities that are new or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **WIC Program**: The DFH will continue to support several activities designed to increase the percentage of women enrolled in WIC who breastfeed their infants.	I	The DFH will continue to provide funding for breast-feeding peer counselors at local WIC sites and will continue to fund two hospital-based breast-feeding counselor programs for post-partum WIC participants

		who deliver at Women & Infants Hospital.
2. **Home Visiting Program**: The Home Visiting Program will continue to support and educate breastfeeding mothers and make referrals to support servcies, as needed.	E	As appropriate, linkages will continue to be made with lactation consultants and other breast-feeding support specialists.
3. **Breast-Feeding Media Campaign**: The DFH will implement a statewide campaign designed to promote breast-feeding.	P	The DFH will implement the activities outlined in its strategic plan designed to increase breast-feeding rates in R.I. The DFH will continue to partner with the R.I. Breast-Feeding Coalition to implement this initiative.
4. **KIDSNET**: KIDSNET will continue to track children's feeding type status through Home Visiting Program data.	I	The DFH will review and improve existing data systems to better assess the breast-feeding rates of WIC participants and the general population.

TABLE 87
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
NPM #9: There are no activities needing revision at this time.		

Use * for new program (<1 yr old)

NPM #10 – Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Population(s): (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 88
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Rhode Island Hearing & Assessment Program (RIHAP):** The DFH will continue to assure that all newborns receive a hearing screening and, if needed, a referral for an assessment and diagnosis, prior to hospital discharge.	I	The DFH will analyze RIHAP data by socio-economic and other risk factors. The DFH will monitor its screening and referral efforts and address the linkage between its findings (CQI process) and outcomes. The DFH will utilize the data to help Rhode Island plan for services for this population on an ongoing basis.
2. **KIDSNET:** KIDSNET will continue to track RIHAP data.	I	Hearing data will continue to routinely downloaded into KIDSNET. The KIDSNET database is utilized to refer children for DFH home visiting services.
3. **Home Visiting Program**: The DFH will continue to provide follow-up services to infants who were identified as being deaf or hard of hearing through RIHAP. The Home Visiting Program will refer children to the Early Intervention Program, as appropriate.	I	Infants who failed a hearing screening prior to discharge through RIHAP will continue to receive follow-up and referral services through the DFH's Home Visiting Program, as appropriate. The Home Visiting Program will also continue to track infants who were lost to follow-up by RIHAP.
4. **Child Development Center (CDC):** The DFH-funded Child Development Center (CDC) will continue to conduct a research project devoted to finding the gene responsible for hearing impairments as well as, assuring linkages with the CDC's specialty unit.	I	Findings from a study of referrals from the NICU and PICU specialty units will be presented in 2001.

TABLE 89
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
NPM #10: There are no activities needing revision at this time.		

Use * for new program (<1 yr)

NPM #11 – Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

Population(s): ( ) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 90
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Early Intervention (EI) Program**: The DFH will continue to pay for specialty and subspecialty care for uninsured and underinsured CSHC, birth to 3 years, who are enrolled in EI.	I	EI is an entitlement program in R.I. The EI Program requires that CSHCN receive services in a "natural setting". Medicaid reimburses for such services. However, many private health insurance plans do not cover such services, including home visits.
2. **Home Visiting Program**: The Home Visiting Program will continue to identify families without health insurance and refer them to RIte Care.	E	As a part of the DFH's Home Visiting Program protocol, families with CSHCN without health insurance will continue to be identified and referred to RIte Care.
3. **CSHCN Program**: The DFH will continue to partner with Family Voices to advocate for more coverage for CSHCN with private health insurance.	P	All CSHCN are not provided coverage for specialty services. The adequacy of rates, non-paying commercial venders, treatment in "natural settings", or lack of coverage for frequency of servcies has been a barrier to quality treatment. Consumer groups will be engaged in an analysis to promote these issues.
4. **Genetics Program**: The DFH's Genetics Team will develop a funding strategy to address the need for preventive genetics counseling and preemptive surgery, which are not currently paid by insurers.	I	Recent advances in genetics will create an increased demand for servcies. The DFH will work closely with state policy-makers and consumer groups to inform groups on the potential impact and enabling the DFH to address these needs.
5. **Traumatic Brain Injury (TBI) Program**: The DFH will continue to maintain a TBI Surveillance database that can be used to link children and adults with TBI to appropriate services, including RIte Care, Medicaid, and SSI.	I	Currently, the DFH is working closely with the Department of Human Services (DHS) on developing strategies to provide improved services and linkages for this population.

TABLE 91
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
5. **Traumatic Brain Injury (TBI) Program**: The TBI Program will be referred to as the Traumatic Brain and Spinal Cord Injury (TBSCI) Program in the DFH's future Title V applications.	I	A 1997 state mandate expanded the TBI Program to include spinal cord injuries.

Use * for new program (<1 yr old)

NPM #12 – Percent of children without health insurance.

Population(s): (X) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

TABLE 92
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. Family Resource Counselor (FRC) Program: The DFH will continue to support FRCs in the state's health centers and outpatient hospital clinics to identify and enroll eligible families into RIte Care.	E	The DFH will continue to fund FRCs in 13 community health centers and 3 hospital clinics to assist families in enrolling in RIte Care, WIC, food stamps, and the state's Family Independence Program (FIP). The DFH will continue to provide training and technical assistance to all FRC sites during the reporting period. The DFH will also finalize the securing of Medicaid match funds for FRC services with the Department of Human Services (DHS).
2. Communications Unit: The DFH will continue to utilize the Communications Unit to promote the MCH Hotline as the single source for information about services for families and other population-based awareness activities.	P	The DFH will continue to conduct a public awareness campaign under the slogan, "Make Health Part of Your Family". Communications Unit staff will continue to attend health fairs and community events and distribute educational and promotional materials in racially/ethnically diverse communities. The campaign is connected to the toll-free MCH Hotline and will continue to refer callers without health insurance to RIte Care, send out information on RIte Care to callers and refer them to FRCs , if additional assistance is needed. DFH Communications Unit staff will continue to participate in state-level inter-agency outreach meetings to keep abreast of outreach activities and major policy changes concerning RIte Care.
3. **Parent-Consultant Program**: The DFH's parent-consultants will continue to assist the DFH with RIte Care outreach activities.	E	Parent-consultants will continue to help the DFH distribute RIte Care mail-in applications to MCH Hotline callers. The DFH's parent-consultants will continue to provide RIte Care outreach assistance at numerous school and childcare sites and in conjunction with an adolescent immunization program with the community-based "Providence Smiles" dental program. DFH Parent Consultants will continue to serve on the state's RIte Care Consumer Advisory Committee, providing insight to reaching potential eligible children. Parent consultants will continue to participate in the DFH's SSDI planning and outreach activities.
4. **School-Based Health Center (SBHC) Program:** The DFH will continue to support RIte Care enrollment activities in the state's 7 SBHCs.	E	SBHCs are an important link to the state's Medicaid managed care program, RIte Care. DFH parent-consultants will continue to conduct creative outreach strategies in SBHCs to enroll significant numbers of adolescents onto RIte Care. The DFH's Communications Unit will work with SBHC staff to support outreach and enrollment in SBHCs. SBHC staff will continue to participate in statewide outreach

		forums.
5. **Family Planning Program**: The DFH will continue to support RIte Care enrollment activities in the state's Title X family planning clinics.	E	Family planning clinics are another important point into Rite Care.
6. **Home Visiting Program**: All families receiving home visiting services will continue to be assessed and referred to RIte Care, as appropriate.	E	DFH home visitors also help families fill out the actual RIte Care enrollment forms and put them in touch with local FRCs who can help them further with the enrollment process.
7. **WIC Program**: The DFH will continue to support outreach activities in WIC settings to identify, refer, and enroll eligible families into RIte Care.	E	Uninsured children on WIC will continue to be referred to the RIte Care Program. Local WIC Program staffs will continue to review WIC income documentation to streamline eligibility at community health centers.
8. **Healthy Child Care**: The DFH will continue to target childcare settings to outreach to families potentially eligible for RIte Care.	E	The DFH will continue to provide training to child care providers to help them understand the RIte Care enrollment process and how to help families access services. The DFH will also continue to target the ChildCare Support Network's (CCSN's) "Parent Information Nights" and Child Opportunity Zone (COZ) Family Centers to distribute RIte Care information to parents. The DFH will explore new childcare populations for distributing information, including family and other "in-home" providers.
9. **Immunization Program**: All children receiving free immunizations will continue to be screened and referred to RIte Care.	E	Children receiving immunization servcies through one of the DFH's two hospital-based clinics or the annual "Big Shots For Little Tots" health fair in inner city Providence will be screened and referred to RIte Care.
10. **Early Intervention (EI) Program**: The DFH's EI Program will continue to assure that potentially eligible CSHCN are identified and referred to RIte Care and SSI.	E	Training for regional EI Program service coordinators and parents will expand to include a review of Medicaid eligibility rules.
11. **Child Opportunity Zone (COZ)/Starting Points Initiatives:** The DFH will continue to support school-linked COZ Family Centers to screen and assist families enroll in RIte Care.	I	The majority of the state's COZs are located in racially/ethnically diverse urban communities.
12. **"Parents As Partners" SSDI Initiative**: This systems development initiative will continue to help families with children, including CSHCN, access health insurance.	I	The DFH will include RIte Care outreach activities as a part of its efforts to expand the "Parents As Partners" model in Providence. The DFH will work closely with the Mayor's Task Force on Early Childhood to implement this initiative in 2001.

TABLE 93
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
NPM #12: There are no activities needing revision at this time.		

Use * for new program (<1 yr old)

NPM #13 – Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Population(s): (X) Pregnant Women (< 19), Mothers and Infants (X) Children (X) CSHCN

TABLE 94
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Home Visiting Program**: The DFH will continue to work to assure that children potentially eligible for Medicaid received home visiting services paid by Medicaid.	I	The DFH will continue to participate in a statewide committee to review, evaluate, and plan for a comprehensive continuum of home visiting services for the state. As a part of its efforts in this area, the DFH will advocate for an increase in existing Medicaid reimbursement rates and the inclusion of prenatal home visits as a reimbursable service.
2. **School-Based Health Center Program (SBHC)**: The DFH will continue to work to assure that adolescents potentially eligible for Medicaid received SBHC services paid by Medicaid.	I	Because most of R.I.'s SBHCs are relatively new and funding is limited, enrollment is not as high as it could be. SBHCs will continue to use family resource counselors (FRCs) to conduct outreach to raise enrollment numbers among Rite Care eligible students in SBHCs and to raise utilization rates. A Rhode Island Assembly on SBHCs will advocate for the expanding of SBHCs in urban high schools
3. **Family Planning Program:** The DFH will continue to work to assure that adolescents potentially eligible for Medicaid have access to confidential family planning services paid by Medicaid.	I	The DFH will develop and implement a survey designed to identify confidentiality concerns and other barriers experienced by adolescents seeking reproductive health services in R.I. Results will be shared with the Rhode Island Department of Human Services (DHS).
4. **Early Intervention Program**: The DFH's EI Program will move to a cost-based reimbursement system to assure maximization of Medicaid funds.	I	The DFH's EI Program and the state Medicaid Office will provide training to regional EI staff in billing to assure maximum use of Medicaid funds.
5. **Child Development Center (CDC**): The DFH will work closely with the CDC to address restructuring reimbursement.	I	A study done by the DFH in 1999 indicated that the CDC did not receive reimbursement for some Medicaid eligible CSHCN receiving services at CDC. The DFH will utilize 2001 to restructure reimbursement and provide training and technical assistance to the CDC.
5. **Healthy Child Care:** The DFH will work to increase the capacity of childcare providers to accommodate CSHCN in a "natural setting".	I	The state's existing childcare subsidy program includes CSHCN. Since there is an acute shortage of regulated childcare slots for CSHCN in R.I., assuring that CSHCN have access to childcare in "natural settings" remains a significant challenge. The DFH will utilize staff and parent-consultants to work with the state Departments of Human Services (DHS); Education; and Children, Youth, & Families (DCYF) to provide training and information to childcare providers about the special childcare needs of CSHCN. Parents with CSHCN will be included on action teams to help assure that the identification of resources for childcare CSHCN is addressed.
5. **"Parents As Partners" SSDI Initiative: The DFH will continue to support community-driven needs assessment & systems development activities.**	I	The DFH will assist the 60-member Mayor's Task Force on early Childhood to implement a plan to improve outcomes for young children in Providence. This plan will include outreach and advocacy activities related to RIte Care.

6. **Family Resource Counselor (FRC) Program:** The DFH will continue to support culturally diverse FRCs in the states' health centers and hospitla outpatient clinics to assist families in enrolling in services, including RIte Care and Medicaid.	I	FRC training will focus on recent changes in RIte Care eligibility rules. The DFH recently secured 50/50 Medicaid match funding for the FRC Program. The DFH will utilize 2001 to pursue a 90/10 Medicaid match option. The DFH will be responsible for a 20-50% match.
7. **Parent-Consultant Program:** The DFH will continue to include parent consultants in activities pertaining to Medicaid reimbursement.	I	A DFH parent consultant will continue to participate on the statewide RIte Care Consumer Advisory Committee. The General Assembly made significant changes to RIte Care's eligibility rules during the 2000 legislative session. DFH parent consultant will continue to be instrumental in the DFH's efforts to assure that families are made aware of these changes.
8. **Genetics Program:** The DFH's Core Genetics Group will identify gaps in access to genetics services and knowledge in Rhode Island.	I	The DFH's Core Genetics Group has established a work group made up representation from the DFH, the March of Dimes, professionals, and consumers to gaps in access to genetics services and knowledge in Rhode Island.

TABLE 95
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
NPM #13: There are no activities needing revision at this time.		

Use * for new program (<1 yr old)

NPM #14 – The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

Population(s): ( ) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 96
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1 **Parent-Consultant Program:** The DFH will continue to fund paid parent-consultants to assure family participation in the state's EI Program and other activities related to CSHCN.	I	The DFH will hire a full-time parent-consultant coordinator to serve as the key liaison to other paid-parent consultants working in the DFH's regional EI programs. The parent-consultant coordinator will continue to provide on-going support to the regional parent-consultants by conducting monthly meetings, by producing and disseminating a monthly parent newsletter, and by participating in DFH EI Program meetings on an on-going basis. Other DFH parent-consultants will continue to participate on the DFH's Genetics Core Team Planning Committee, the Genetics Task Force, and in the Disabilities & Health Program. On-going in-service training for DFH's paid parent-consultants will continue to be provided through the DFH's Parent-Consultant Program.
2**. Early Intervention (EI) Program**: The DFH will continue to support paid parent-consultants in the 5 regional EI programs.	I	EI is mandated to assure that parents participate in the EI services planning process. The EI Program will continue to utilize parent-consultants to conduct outreach and

		education, translation and interpretation, program monitoring, materials review, community advocacy, family surveys, and grant reviews and to provide parent-to-parent support, and the parent perspective during regional EI program annual site reviews. As of September 2000, the EI Program's parent-consultants will no longer be paid by the regional EI Programs, but by a separate agency. As a result, the DFH's EI parent-consultants will be incorporated into the DFH's overall Parent-Consultant Program funding mechanism.
3. **SSI Team:** Parents from the Rhode Island Parent Information Network (RIPIN) and Family Voices will continue to participate on the DFH's SSI Team.	I	Through the SSI Team, the DFH will develop a parent/professional team to speak to parent groups about SSI.
4. **CSHCN Program**: The DFH will continue to support the community-based advocacy group Family Voices to assure family participation in policy and program planning and implementation for CSHCN on the national and state levels.	E	Family Voices Rhode Island is one of six states to implement a Family-To-Family Information Center. In this capacity Family Voices will represent families and their perspective in a number of statewide policy discussions involving CSHCN. In addition, Family Voices will continue to provide public testimony on both the state and national levels on issues affecting CSHCN.
5. **Healthy Child Care**: The DFH will continue to work to assure that CSHCN have access to childcare in "natural settings".	E	The DFH will work with the Rhode Island Parent Information Network (RIPIN), Family Voices, the Child Care Support Network (CCSN), the Healthy Childcare America Advisory Board, and DFH parent consultants to provide training and information to providers to help them to better accommodate CSHCN in child care. The DFH will increase parent outreach & education opportunities in child care settings through increased collaboration with the DFH's Parent Consultant Program. The DFH will include parents with CSHCN on child care advisory boards to assure that the identification of resources for this population remains a priority.
6. **Lead Outreach & Education Services**: The DFH supported a parent consultant to participate in statewide childhood lead poisoning prevention efforts.	E	The parent consultant worked directly with the DFH's outreach & education coordinator to implement ongoing public education activities with an emphasis on parent-to-parent outreach and communities activities designed to increase public awareness about lead poisoning.

TABLE 97
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
NPM #14: There are no activities needing revision at this time.		

Use * for new program (<1 yr old)

NPM #15 – Percent of very low birth weight live births.

Population(s): (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 98

Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Home Visiting Program**: The Home Visiting Program will continue to provide pregnant women and families with young children with outreach, education, follow-up, and referral services.	I	The prenatal home visits that the Home Visiting Program provides help prevent low birthweight births.
2. **Women's Health Screening & Referral Program (WHSRP):** The WHSRP will continue to provide no cost pregnancy testing and comprehensive health risk assessment and referral to women seeking a pregnancy test in the DFH's family planning clinics.	I	The WHSRP promotes early pregnancy identification and prenatal care and referral to support services for identified health risks, such as tobacco cessation. The DFH will explore the feasibility of securing Medicaid match funds to address identified gaps in the system of care for women and to expand the WHSRP to additional sites.
3. **Family Resource Counselor (FRC) Program:** The DFH will continue to provide support to FRCs in 13 community health centers and 3 hospital clinics to assist in enrolling families onto RIte Care, WIC, food stamps, and FIP.	I	The FRC Program assures that pregnant women are enrolled into RIte Care and have access to prenatal care and other support services early in pregnancy.
4. **Newborn Screening Program**: The DFH will continue to identify low birthweight newborns and refer them to the Home Visiting Program for appropriate follow-up services.	I	Low birthweight (<2500 grams) will continue to be considered to be at risk and will be referred to the Home Visiting Program. The Newborn Screening Program utilizes KIDSNET to determine risk and to make referrals.
5. **Family Planning Program**: The DFH's Family Planning Program will continue to provide low-income men, women and adolescents with access to confidential reproductive health services, including family planning services.	I	The DFH's Family Planning Program, which is funded through a combination of federal Title X and state "family life" funds, is dedicated to preventing unintended pregnancies. The DFH's Family Planning Program remains significantly under-funded.
6. **Vasectomy Program**: The DFH will continue to partner with the Rhode Department of Human Services (DHS), on a project to provide no cost vasectomies to uninsured adult men throughout the state.	D	The Vasectomy Program was designed to expand this population's access to vasectomy services and prevent unintended pregnancies. The DFH will utilize 2001 to try to increase the number of participating physicians who have Spanish and/or Portuguese-speaking service capacity.
7. **Child Development Center (CDC)**: The DFH will continue to support a study, conducted by the CDC, of low birthweight infants to improve systems of care.	I	The CDC continues to collect data on low birthweight infants born in 1998 who are at risk and linking data on this cohort with outcome data sets from Women & Infants Hospital NICU Follow-Up Program. Continuous quality assurance as well as future study findings will be used to improve systems of care for low birthweight infants.
8. **"Parents As Partners" SSDI Initiative**: This systems development initiative helped "hard-to-reach" families access WIC, RIte Care, Home Visiting, Newborn Screening, and Early Intervention services.	I	Increasing access and enrollment in these programs helps assure health pregnancy outcomes. The DFH will continue to work with the Mayor's Task Force on Early Childhood. Activities for 2001will include the implementation of a plan to assure that young children in Providence are healthy and ready to learn at school entry.
10. **Chlamydia Project**: The DFH will continue to support a project designed to reduce the prevalence of Chlamydia in at-risk	I	HEALTH's DFH, Office of STDs, Laboratories will continue to work together to provide no cost Chlamydia screening, education, and treatment to low-

women, including adolescents.		income uninsured women (including adolescents) receiving services through the DFH's largest family planning clinic in the racially/ethnically diverse City of Providence. In 2000, the Chlamydia Project was expanded to one School-Based Health Center (SBHC) site. The positivity rate for the SBHC teens who were screened in 2000 was 21.1%. The DFH and the Office of STD plans to utilize 2001 to explore the feasibility of expanding the project to the Women's Prison.
10. **WIC Program**: The DFH will increase pregnant women's access to WIC by establishing comprehensive approach to increase WIC enrollment.	E	Although WIC remains a core component of the state's community health centers, there has been an increase in the number of WIC clients being served through private providers serving the RIte Care population. The DFH will establish a WIC Physician Education & Outreach Program targeting private providers serving the Rite Care population as a way to increase enrollment.

TABLE 99
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
NPM #15: There are no activities needing revision at this time.		

Use * for new program (<1 yr old)

NPM #16 – The rate (per 100,000) of suicide deaths among youths 15-19.

Population(s): ( ) Pregnant Women, Mothers and Infants (X) Children (Adolescents) (X) CSHCN

TABLE 100
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Adolescent Media Campaign**: The DFH's planned adolescent media campaign will address the mental health needs of adolescents through collateral material and education about youth developmental needs.	P	Parents and other caregivers with concerns about adolescent mental health issues will be able to call the DFH's MCH Hotline and request information about where they can go for additional information and support.
2. **Men 2 B Program**: Men who participate in this initiative will continue to receive training in youth asset development and adolescent mental health issues.	I	Teens in need of mental health servcies will continue to be referred to appropriate professionals.
3. **Home Visiting Program**: Teens receiving home visits will continue to be referred for mental health services, as appropriate.	I	Pregnant & Parenting teens are sometimes referred to the Home Visiting Program. Others receive home visits through the Department of Human Services (DHS) adolescent self-sufficiency programs.
4. **School-Based Health Center (SBHC) Program:** The DFH's SBHCs will continue to provide mental health counseling and referral services.	I	The Rhode Island Assembly on SBHCs, the SBHC Network, and DFH staff will draft guidance and policies for a SBHC model that includes comprehensive mental and behavioral health services provided on site and/or through a network of community providers. The DFH

		will work to resolve issues related to credentialing and provider networks in 2001.
5. **CSHCN Program**: The DFH will continue to advocate for the inclusion of children's mental health issues in the state' mental health plan.	I	Currently, the plan primarily focuses on the mental health needs of adults with chronic mental illness.
6. **Healthy Child Care**: The DFH will work to increase capacity to link childcare providers and families to mental health resources.	I	The Starting Right Program, which is administered by the Department of Human Services (DHS), expands the state's existing childcare subsidy program to include adolescents in after-school settings. As a result, there are new opportunities to target adolescents in after school programs that may have a mental health concern. The DFH, in collaboration with CHILDSPAN, Rhode Island hospital, and the Mental Health Association of Rhode Island (MHARI), will continue to support its annual "Critical Issues in Childcare" conference for childcare providers, which will focus on mental health issues in childcare. The mental health needs of adolescents will be included as a part of this conference. The DFH will also work with the Child Care Support Network (CCSN) to identify and connect childcare providers with appropriate community mental health resources. The CCSN will develop and distribute information to providers and will work through its parent education component to educate families about available community mental health resources.
7. **Northeast Injury Prevention Network**: The DFH will continue to participate in this regional network's Suicide Prevention Project in collaboration with HEALTH's Division of Disease Control & Prevention.	I	The Rhode Island Team developed a draft plan at the June 2000 invitational conference for Suicide Prevention. That plan will begin implementation by the end of FY2000.

TABLE 101
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
7. **Northeast Injury Prevention Network**: The Suicide Prevention Project is a new initiative less than a year old.	I	

Use * for new program (<1 yr old)

NPM #17 – Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

Population(s): (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 102
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Women's Health Screening & Referral Program (WHSRP):** The DFH will continue to provide no cost pregnancy testing and comprehensive risk assessment and referral	I	The majority of Rhode Island's very low birthweight babies are delivered at Women & Infants Hospital. The DFH has focused on developing the infrastructure necessary to identify women who are at risk for

services to women.		delivering a low birthweight infant and assure that they are linked to appropriate prenatal care services. Women who participate in the WHSRP who are at risk for delivering very low birthweight babies will continue to be identified and referred for appropriate prenatal care and other supports early in pregnancy.
2. Home Visiting Program: DFH Home visitors will continue to assess at risk women receiving prenatal home visits and refer for medical treatment and other supports.	I	The DFH's Home Visiting Program is an important link to assuring that high-risk pregnant women are identifed and referred to appropriate follow-up care early in pregnancy. The DFH will encourage and promote, through KIDSNET, the linkage of OB/GYN service systems with pediatric service systems.
3. **Early Intervention Program**: The DFH will strengthen linkages with the pediatric and neonatal intensive care units at Women & Infants hospital to assure early contact with EI services.	I	A pediatric development physician working as a consultant for the DFH at the CDC will continue to provide training to personnel at the NICUs and PICUs at Women & Infants Hospital. This initiative assures that infants who are delivered at high-risk facilities are linked to early intervention services prior to discharge
4. **Child Development Center (CDC):** The CDC provided training for Women & Infants Hospital and Hasbro Children's Hospital staff to assure the coordination of services and a medical home for this population.	E	The DFH's physician consultant at CDC will continue to provide training to personnel at the NICUs and PICUs at Women & Infants Hospital. This initiative assures that infants with medically complex needs in high-risk facilities are linked to appropriate follow-up services in a timely manner.
5. **Disabilities & Health Program**: The DFH will train doctors in the WEEFIM model, which assesses the functional level of CSHCN, ages birth through 7.	E	The WEEFIM model assesses the "whole child", and includes their resiliency. The DFH will continue to support training on identification and functional assessment of CSHCN.

TABLE 103
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
5. **Disabilities & Health Program**: This activity is a new initiative less than a year old.	E	

Use * for new program (<1 yr old)

NPM #18 – Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Population(s): (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 104
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. Women's Health Screening & Referral Program (WHSRP): The DFH will continue to provide no cost pregnancy testing and health risk assessment and referral to women.	I	By providing no cost pregnancy testing and comprehensive health risk assessment and referral, the DFH is able to assure that pregnant women are identified and referred to prenatal care and other community support services early in pregnancy. The DFH plans to expand the WHSRP to other sites in 2001.

2. **"Parents As Partners" SSDI Initiative:** The DFH will continue to support community needs assessment and strategic planning to increase utilization of preventive health services, including early prenatal care.	I	The DFH will continue to support activities designed to, among other things, increase the number of pregnant women receiving prenatal care in the first trimester. The DFH will expand the "Parents As Partners" model to Providence in 2001.
3. **Family Resource Counselor (FRC) Program: The** DFH will continue to support culturally diverse FRCs in the state's health centers and hospital outpatient clinics t identify and enroll eligible families into RIte Care.	E	The DFH's FRCs will continue to provide culturally competent outreach to pregnant women to encourage early prenatal care and medical coverage. The DFH's FRC training efforts will focus on recent changes in RIte Care eligibility rules.
4. **Home Visiting Program**: The DFH will continue to provide education to pregnant women regarding the importance of early prenatal care.	E	At risk women will be referred to medical care and RIte Care, as appropriate
5. **Child Opportunity Zone (COZ)/Starting Points Initiatives:** The DFH will continue to support school-linked COZ Family Centers to link families to RIte Care and a "medical home".	I	The majority of the state's COZs are located in racially/ethnically diverse urban communities.
6. **WIC Program**: The DFH will increase pregnant women's access on WIC who receive prenatal care in the first trimester through early enrollment in WIC and RIte Care.	E	The DFH will increase access to WIC among pregnant women by establishing WIC/Insurer outreach initiatives with high volume RIte Care prenatal care providers.

TABLE 105
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
NPM #18: There are no activities needing revision at this time.		

*** Use * for new program (<1 yr old)**

SPM #1 –The number and percentage of children >18 months in childcare who are up-to-date on their immunizations.

Population(s) served: ( ) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

TABLE 106
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1**. Child Opportunity Zone (COZ)/Starting Points**: The DFH supported Child Opportunity Zone (COZ) Family Centers to provide child care and family centers with information in local schools and after-school session for young children.	I	COZ sites will continue to distribute culturally appropriate information on a variety of topics, including immunizations. COZs will also provide culturally appropriate training and support to "family" child care providers. "Family" child care providers have limited access to child care health and safety information.
2. **Immunization Program**: The DFH will continue to conduct assessments at licensed child care centers, community health centers, WIC sites, kindergartens, and private physicians offices to monitor trends in the age-appropriate immunization status of children.	P	The DFH will continue to provide these settings with feedback on historical and current rates as well as opportunities on how to improve their rates. The DFH will continue to provide ongoing informational services and distribute materials to ensure that childcare sites are aware of the current recommendations and regulations

		regarding childhood immunizations.
3. **Healthy Child Care**: The DFH will continue to provide training and technical assistance to childcare sites to assure that children are up-to-date on their immunizations.	E	The DFH will provide childcare providers with training through CHILDSPAN and resource materials through CHILDSPAN and the Childcare Support Network (CCSN). The DFH will also work closely with the Rhode Island Chapter of the American Academy of Pediatrics (AAP) to provide pediatricians who attend conferences with information about the importance of childhood immunizations.
4. **KIDSNET:** The DFH will create a statewide immunization registry for all children, including CSHCN, living in Rhode Island.	I	The DFH plans to have all primary care providers on-line in 2001. Once fully implemented, KIDSNET will have complete immunization histories for all children born as of 1/1/97. The DFH plans to track the immunization compliance for the DFH's targeted population of all children linked with a provider.
5. **Home Visiting Program**: The Home visiting Program will continue to provide outreach to families whose children are out of compliance with immunization protocols, based on KIDSNET data.	I	The DFH's Home Visiting Program will continue to serve families throughout the state. Families will continue to receive culturally appropriate services through culturally diverse staff and education materials..
6. **Immunization Media Campaign**: The DFH will continue to conduct public education, outreach and promotion activities related to childhood immunization.	P	The DFH and the statewide Immunization Action Coalition will collaborate in a targeted effort to reduce "missed opportunities" through the creation of opportunities for immunization for children in child care.
7. **Parent Consultant Program:**	E	The DFH will increase parent outreach & education opportunities in child care settings through increased collaboration with the DFH's Parent Consultant Program.

TABLE 107
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
SPM #1: There are no activities needing revision at this time.		

*** Use * for new program (<1 yr old)**

SPM #2 –The percentage of students in schools with School-Based Health Centers (SBHCs) who are enrolled in SBHCs.

Population(s) served: ( ) Pregnant Women, Mothers and Infants (X) Children (Adolescents) (X) CSHCN

TABLE 108
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comment1s
1. **School-Based Health Center (SBHC) Program**: The DFH's SBHCs will continue to conduct outreach to increase enrollment in the state's 7 SBHCs.	I	The DFH's SBHCs need more funding to fully support the program after private foundation funding ends. Rhode Island's SBHCs have lower enrollment rates than is the norm in other states. The DFH will work with the SBHC Network to determine the best way to assess utilization barriers. The DFH will provide technical assistance to each SBHC to help them develop a

		utilization improvement plan in 2001.
2. **Family Planning Program**: The DFH will continue to assure strong linkages between the state's SBHCs and the Family Planning Program.	I	The DFH will provide local SBHC staff with training and technical assistance about the federal Title X Family Planning Program on an ongoing basis. SBHC students in need of birth control services will continue to be referred to Title X sites.
3. **Communication Unit**: The DFH's Communications Unit will work with the SBHC Program to identify ways to increase public awareness about the value of SBHCs.	P	The DFH's Communications Unit will work with SBHCs to increase enrollment and utilization of SBHC services through the creation of culturally appropriate materials and simplified forms.
4. **Immunization Program**: The DFH will continue to support the "Vaccinate Before You Graduate" initiative targeting teens.	I	The DFH will utilize 2001 to expand the "Vaccinate Before You Graduate" initiative to high school seniors in the state's five racially/culturally diverse urban "core" communities (Woonsocket, Central Falls, Providence, Pawtucket, and Newport). All of the state's SBHCs will be covered through this effort.

TABLE 109
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
SPM #2: There are no activities needing revision at this time.		

*** Use * for new program (<1 yr old)**

SPM #3 –The proportion of pregnant women who receive an alpha-fetoprotein (AFP) test.

Population(s) served: (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 110
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Child Development Center (CDC):** The DFH will continue to work to assure parent satisfaction with CDC services.	I	The DFH will support the CDC to conduct a survey to learn what services were offered and/or received in the prenatal period to families who have children with a genetic related condition. In 2000, a workgroup developed the tool, which is in currently draft form. The tool will be piloted at CDC and results from the survey will be available in 2000. The DFH will utilize 2001 to implement the survey in other sites in Rhode Island.
2. **Women's Health Screening & Referral Program (WHSRP)**: The WHSRP will continue to provide risk assessment and referral for women who had a pregnancy test who may be at risk of having a child with a condition that has genetic precursors.	I	At-risk women with positive pregnancy test results will continue to be referred to genetics counseling. Unfortunately, uninsured low-income non-pregnant women's access to genetics counseling services is limited. The DFH will address this gap in the system of care for women in 2001. All women participating in the WHSRP receive education about the importance of taking folic acid prior to pregnancy.
3. **Genetics Program**: The DFH's Genetics Team plans to develop community-based	I	The DFH's HRSA infrastructure grant will continue to provide resources for the development of a statewide

partnerships and linkages to expand access to genetics services.		strategic plan for genetics. A DFH parent-consultant will continue to work on genetics issues in conjunction with the DFH's Core Genetics Team.
4. **WIC Program**: The DFH will continue to assure that post-partum women receiving WIC servcies receive information about the importance of folic acid.	E	All local WIC agencies will continue to receive promotional materials about folic acid to distribute. DFH parent-consultants will continue to review, evaluate, and translate printed informational materials targeting consumers.
5. **Family Planning Program**: The DFH will attempt to secure continued funding to provide folic acid to uninsured, low-income women receiving family planning services through the state's Title X family planning clinics.	E	Title X funding for folic acid for uninsured, low-income women receiving services through the DFH's family planning clinics has ended. The DFH will express its continued interest in receiving samples of multi-vitamins with folic acid from the March of Dimes for this population.

TABLE 111
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
SPM #3: There are no activities needing revision at this time.		

*** Use * for new program (<1 yr old)**

SPM #4 –Percent of women who receive prenatal care in the first trimester by race/ethnicity and socio-economic status.

Population(s) served: (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 112
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Women's Health, Screening and Referral Program (WHSRP):** The DFH will explore the feasibility of linking the WHSRP database with the Family Planning Program database to determine the percentage of women participating in the WHSRP who received prenatal care in the first trimester by race/ethnicity and socio-economic status.	I	The WHSRP is operated by the DFH's family planning clinics. Therefore, it is possible to link the WHSRP database with the Family Planning database. The DFH will explore the feasibility of implementing this linkage in 2001.
2. Newborn Screening Program: Level I screening data will continue to help determine the race/ethnicity and socio-economic status of families receiving home visits through the Home Visiting Program.	I	KIDSNET is utilized to refer pregnant women to prenatal care, as appropriate. The data will continue to be collected from R.I.'s birthing hospitals.
3. Home Visiting Program: The Home Visiting Program will continue to track the percentage of women who received prenatal care in the first trimester by race/ethnicity and socio-economic status.	I	Home Visitors will continue to educate pregnant women about the importance of prenatal care during the first trimester and assure that they are linked to appropriate medical care. The Home Visiting Program will continue to assure that its staff reflects the community populations served within the constraints of low unemployment and their budgets.

TABLE 113

Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
SPM #4: There are no activities needing revision at this time.		

*** Use * for new program (<1 yr old)**

SPM #5 –Percent of children tested with lead levels greater than or equal to 10 ug/dl by race/ethnicity and socio-economic status.

Population(s) served: ( ) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

TABLE 114
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1.**KIDSNET**: KIDS NET will continue to track providers' compliance with current lead screening protocols. Plans to send primary care providers reports for their pediatric patients 15 months of age and older who are not in compliance with existing lead screening protocols, beginning in 2001.		KIDSNET will send primary care providers reports for their pediatric patients 15 months of age and older who are not in compliance with existing lead screening protocols, beginning in 2001. This technical assistance/quality assurance activity is designed to increase timely lead screening.
2. **Childhood Lead Screening Program**: The DFH will continue to assure that all children in Rhode Island are screened in accordance with existing guidelines and state law.	E	The DFH will assess the needs of uninsured and under-insured children under age six by maintaining the support of the no cost community-based clinics at St. Joseph Hospital and Hasbro Children's Hospital. The DFH will also produce a final report (validation study) of the DFH's 1999 summer door-to-door lead screening program.
3. **Lead Case Management Services**: The DFH will continue to refer significantly lead poisoned children to either the Lead Center for comprehensive care or the Home Visiting Program for parent lead education in the home.		The DFH's Lead Program will continue to provide additional follow-up, technical assistance, and monitoring.
4. **Home Visiting Program**: The DFH will continue to provide children with moderately elevated lead levels (Pb = 10-15 ug/dl) with parent lead education in the home as a preventive measure.	I	Home Visitors will continue to be an important resource for families with children with elevated lead levels throughout the state.
5. **Environmental Lead Inspections**: The DFH will continue to offer an environmental lead inspection to all significantly lead poisoned children in the state.	E	The DFH will explore the feasibility of dropping the existing level for triggering lead inspection and case management services from 20 ug/dl to 15 ug/dl.
6. **Lead Outreach & Education Services:** The DFH will continue to conduct lead education & outreach activities on an ongoing basis.	P	The DFH will conduct community culturally and linguistically appropriate presentations and seminars in collaboration with school departments, parent support organizations working with minority populations, Head Start Programs, Starting Points sites, and other groups; conduct monthly targeted outreach mailings with educational and promotional materials to parents of children with lead levels 10-19 ug/dl; participate in health fairs and other community-based parent activities to disseminate incentives and

		lead prevention messages; to increase the network of community-based educators participating in the DFH's Train the Trainers; and to conduct targeted outreach to health care providers to emphasize the DFH's existing screening guidelines, offer program updates, and assess effective ways to provide further technical assistance.
6. **Healthy Child Care**: The DFH will continue to provide information and education to parents with young children in childcare and childcare providers about lead screening and lead poisoning prevention.	E	The DFH will continue to provide support to the Child Care Support Network (CCSN), which uses lending tote bags on a variety of topics, including childhood lead poisoning prevention. Also, childcare providers will be routinely included in the DFH's mass mail outs of educational materials, which will include information about childhood lead poisoning prevention. The DFH will expand its efforts in this area to include children in the Narragansett Indian Tribe's "Little Moccasins" childhood lead poisoning prevention program.
8. **WIC Program**: The DFH will assure that families of children with lead levels ≥10 ug/dl are referred to WIC for nutritional counseling and access to nutritional foods/	E	The DFH will utilize the KIDSNET database to determine lead risk for children receiving WIC services and refer children with lead levels ≥ 10 ug/dl for nutritional counseling and access to nutritional foods. The DFH will conduct monthly mailings to families with children receiving WIC services with lead levels ≥ 10 ug/dl. The mailings, which will be offered in several languages, will contain information about lead hazard reduction and the role of a healthy diet in reducing elevated lead levels.
9. **Early Intervention (EI) Program**: The DFH will continue to provide training to regional EI staff to identify lead poisoned children and refer them to appropriate follow-up services.	I	EI services coordinators will continue to include each child's lead-related needs as a part of their IFSP.
10. **Immunization Program**: The DFH will continue to integrate lead screening activities with its immunization activities.	I	The DFH will survey all pre-school, Head Start, & Kindergarten providers for lead testing compliance. The DFH will also determine lead testing compliance during immunization assessments at private provider sites.
11. **"Parents As Partners" SSDI Initiative**: The DFH's SSDI Initiative will continue to include lead outreach to "hard-to-reach" families.	I	The DFH will expand the "Parents As Partners" model to Providence in 2001. The racially/ethnically diverse "core" urban City of Providence has high rates of childhood lead poisoning.
12. **Child opportunity Zone (COZ)/Starting Points Initiatives:** The DFH will continue to support Child Opportunity Zone (COZ) Family Centers that provide lead education to families.	E	The DFH funded 9 COZ sites in racially/ethnically diverse urban communities to incorporate lead education as a part of the ongoing support services that they provide to families. COZs provide families with information on a variety of topics, including lead poisoning, and linkages to community-based support services.

TABLE 115
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
SPM #5: There are no activities needing		

revision at this time.		

*** Use * for new program (<1 yr old)**

SPM #6 –Percent of 9th graders who are expected to graduate from high school.

Population(s) served: ( ) Pregnant Women, Mothers and Infants (X) Children (Adolescents) (X) CSHCN

TABLE 116
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **School Based Health Center (SBHC) Program**: The DFH's SBHCs will continue to provide a comprehensive array of preventive health and mental health servcies to youth in an in-school setting.	I	A pilot study conducted by the DFH indicated a correlation between SBHC usage and absenteeism. National studies indicate a relationship between graduation rates and SBHC usage. The DFH plans to implement a SBHC in every urban high school in the state.
2. Family Planning Program: The DFH supported confidential family planning services to adolescents.	I	Family planning helps prevent unwanted pregnancies, which can interfere with educational goals. The DFH will increase the number of teens served by including Planned Parenthood Of Rhode Island's Teen Clinic to the DFH's existing family planning network.
3. **Men 2 B Program**: The DFH's Men 2 B initiative will continue to utilize a youth development approach to build community capacity for strong caring adults and access to health and mental health services for youth.	E	The Men 2 B Program will develop a curriculum that can be used with role models as well as parents of adolescents in school, work, or faith organization settings.
3. **Disabilities & Health Program**: The DFH will continue to assure that CSHCN who are transitioning from school to work have the supports and skills needed for a productive adulthood.	I	In collaboration with the state Department of Education, the DFH will continue to support a three year evaluation study of students of the effectiveness of services for CSHCN who have recently completed high school. The survey includes questions focusing on health care access. Working with the statewide Transition Council, the DFH will offer strategies for addressing identified needs. By January of 2001, a major analysis will be available, with information from about two-thirds of the school districts.
5. **Adolescent Media Campaign**: The DFH will implement a statewide media campaign targeting parents and other adult caregivers of adolescents.	P	Statewide media materials developed in FY2000 will be kicked-off in January 2001. Media campaign materials call on adults to build positive relationships through communication with youth. A pre-post telephone survey will evaluate changes in knowledge, attitudes and practices. Campaign materials include television and radio spots in English and Spanish, posters, bus cards, brochures, and informational sheets on "Ten Tips For Parenting Teens". The DFH will seek corporate and state department partners to implement 3 waves and to develop new themes.
6. **Healthy Child Care**: The DFH will continue to support parenting classes in childcare settings on developmental topics impacting children, including adolescents.	E	Parent-consultants hired through the DFH's Health Child Care grant will receive training on adolescent health and development issues.
7. **Immunization Program**: The DFH will expand its "Vaccinate Before You Graduate"	I	The DFH will also mail and provide technical assistance to other interested cities and towns

Program to all senior high school students in the state's 5 "core" urban communities.		throughout the state. The DFH will collaborate with the statewide Immunization Action Coalition to develop marketing materials for the "Vaccinate Before You Graduate" Program to be utilized by Rotary Clubs and other community-based partners interested in presenting the initiative to non-core cities and towns.
8. **Youth Input**: The DFH will fund Youth in Action, a youth led community service organization, to ensure youth input into DFH initiatives.	E	The DFH will invest parent-consultant funds in FY2001 to expand the scope of services that Youth In Action and other youth run organizations will provide to the DFH and to engage more youth and their parents in strategic planning and program design.
9. **Starting Right Program**: DFH staff will continue to participate on the Department of Human Services (DHS) Starting Right Youth Services Implementation Committee.	I	The Committee is charged with facilitating implementation of the Family Independence Program (FIP) entitlement initiative for after-school programs for youth ages 10-16. The group will provide technical assistance to communities and develop policy, long-term financing options, and best practices recommendations for the state Children's Cabinet. The DFH will continue to fund health education projects in four after-school programs until June 30, 2001. Two will address sexuality issues and two will address physical fitness and nutrition issues. During FY2001 plans to issue an RFP to add four additional sites, a father's component, and a suicide prevention project to the initiative.

TABLE 117
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
8. **Youth Input (*)**: This is a new initiative less than a year old.	E	
9. **Starting Right Program (*)**: This is a new initiative less than a year old.	I	

*** Use * for new program (<1 yr old)**

SPM #7 –Number of children with Individualized Family Service Plans (IFSPs) for whom an Individual Education Plan (IEP) is developed.

Population(s) served: ( ) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 118
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Early Intervention (EI) Program**: The DFH's regional EI programs will continue to provide comprehensive transition services for CSHCN who will be turning three years old.	I	The DFH's regional EI programs establish annual transition goals to assure that timelines specified in IDEA are appropriately met. The DFH & the Department of Education have ongoing work to assure appropriate transition. The DFH will provide funding for training regional EI and school staff for transition

		planning. At the same time, Medicaid is considering reimbursing schools that utilize IEPs to develop IEFSPs at a higher rate than schools that do not.
2. **Parent-Consultant Program**: The DFH will continue to support parent consultants in the regional EI programs to support families with CSHCN at transition meetings and inform families about procedural safeguards.	I	Plans are underway to provide parent-consultant support for families during the Individual Family Service Plan (IFSP) process and during transition.
2. **Disabilities & Health Program**: The DFH will develop recommendations for effective statewide child outreach standards.	I	Child Outreach entails screening pre-schoolers, ages 3-5, for developmental delays. The DFH, in collaboration with the state Department of Education, is in the process of conducting an analysis of survey results from 24 of Rhode Island's communities. Findings will be included in a report along with recommendation for effective statewide child outreach standards. A DFH parent consultant is coordinating this project.

TABLE 119
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
SPM #7: There are no activities needing revision at this time.		

*** Use * for new program (<1 yr old)**

SPM #8 –Number of infants and children (< 5 years of age) in the WIC Program with statures for weight that are either , 10th percentile or > 90th percentile.

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

TABLE 120
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. Family Resource Counselor (FRC) Program: FRCs will continue to screen all children and pregnant women presenting for care at community health centers and hospital-based clinics and refer them to WIC, as appropriate.	E	The DFH will continue to provide support to 13 community health centers and 3 hospital outpatient clinics to fund culturally diverse FRCs. The majority of these sites are located in racially/ethnically diverse urban communities.
2. **Home Visiting Program**: Home Visitors will continue to refer families to WIC and provide families with nutrition & feeding education.	E	The Home Visiting Program will continue to serve families throughout the state. Families living in racially/ethnically diverse communities will continue to receive culturally appropriate services.
3. **WIC Program**: The WIC Program will continue to screen for normal growth patterns of children and provide nutritious supplemental foods and consumer-friendly information and education to families in WIC.	E	The DFH will implement the use of a body mass index for children > 2 years old, based on U.S. Centers for Disease Control (CDC) recommendations. WIC will continue to provide specialized food packages based on participant's needs and educate WIC families about basic nutrition and the importance of physical activity. WIC services will continue to be provided based on the identified risk, age, education, culture, and language status of participating families.

4. **WIC Media Campaign**: The DFH will implement a media campaign designed to increase WIC enrollment and retention with a focus on customer service at local WIC agencies and WIC stores.	P	The media campaign will target working families from racially/ethnically diverse communities, health care providers, and WIC vendors.
5. **Parent-Consultant Program**: The DFH will continue to support parent-consultants to review & create culturally appropriate printed nutrition education and outreach materials for families in WIC.	E	The DFH's WIC Program will continue to utilize culturally diverse parent consultants.
6. **Farmers Market Nutrition Program (FMNP):** The DFH will continue and expand access to the FMNP to increase access to fresh, locally grown produce and related nutrition information among WIC participants.	E	The DFH will expand the number of FMNP sites in the state by one to include a new site in East Providence. A significant proportion of East Providence's population is of Portuguese descent. In addition, the DFH will utilize 2001 to collaborate with Johnson & Wales University to provide cooking demonstrations at FMNP sites to introduce consumers to new ways of preparing fresh fruits and vegetables. Recipes will be culturally appropriate and the DFH will support translators at FMNP sites, as appropriate.

TABLE 121
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
SPM #8: There are no activities needing revision at this time.		

*** Use * for new program (<1 yr old)**

SPM #9 –Number of at risk newborns who receive a home visit in the early newborn period (up to 90 days after birth).

Population(s) served: (X) Pregnant Women, Mothers and Infants ( ) Children (X) CSHCN

TABLE 122
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Newborn Screening Program**: The DFH will continue to determine risk factors and made referrals to the Home Visiting Program.	I	The DFH will continue to define the early newborn period as being up to 90 days after a child is born.
2. **Home Visiting Program**: The DFH will continue to provide home visiting services to families who had a newborn at risk for developmental delay.	I	The Home Visiting Program will continue to visit at risk newborns within 7 days of hospital discharge and priority referrals within 24 hours of discharge and assure that they are referred to support services, as appropriate. Growth, loss of categorical funding, and low Medicaid rates has left the Home Visiting Program with a financial shortfall.
3. **KIDSNET**: The DFH will continue to utilize KIDSNET to tracked newborn screening and home visiting data.	I	KIDSNET will continue to track all at risk newborns to assure that they have a Level II screening and referral to Early Intervention, as appropriate.
4. **Early Intervention (EI) Program**: The Home Visiting Program will continue to identify and refer newborns eligible for early	I	Children enrolled in EI, in most cases, receive home visits from EI service coordinators on an on-going basis.

intervention services.		
5. **"Parents As Partners" SSDI Initiative**: This systems development initiative will continue to help "hard-to-reach" families access home visiting services.	I	The DFH will work with the Mayor's Task force on Early Childhood to expand the "Parents As Partners" model into Providence. The plan will include culturally appropriate outreach to at-risk families.

TABLE 123
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
SPM #9: There are no activities needing revision at this time.		

*** Use * for new program (<1 yr old)**

SPM #10 –Number of completed family surveys.

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

TABLE 124
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
1. **Rhode Island Food Security Monitoring Project**: The DFH will continue to monitor the prevalence of hunger and food insecurity among households living in poverty areas.	I	During 2001, results from the second RIFSM Project will be analyzed and the findings publicly released. Also, plans for repeating and expanding the survey in 2001 will be developed.
2. **Family Planning Program:** The DFH will survey adolescents to determine if they have concerns about confidentiality that affects their decision to seek reproductive health services.	I	The DFH will partner with the youth-led organization, Youth In Action, to survey about 200 adolescents. The DFH will present the results of this initiative in 2001.
3. **Adolescent Media Campaign**: The DFH will survey adults and teens on adult/teen relationships.	I	As a part of the DFH's Adolescent Media Campaign, the DFH will complete a baseline and follow-up survey to track changes in knowledge, attitudes, and practices of adults regarding their relationships, including communication, with teens. Teens will also be surveyed to assess their perceptions of adult/teen relationships.

TABLE 125
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
2. **Family Planning Program (*):** This survey is a new initiative less than one year old.	I	
3. **Adolescent Media Campaign (*)**: This survey is a new initiative less than a year old.	I	

Use * for new program (<1 yr old)

4.2 Other Program Activities

In December of 1998, the Rhode Island Department of Health (HEALTH) was notified that Rhode Island Hospital (Lifespan) would no longer fund its statewide Poison Control Center after April 1999, due to budgetary shortfalls. After a series of meetings with representatives form Rhode Island Hospital and the Governor's policy office, the state legislature provided the Hospital with an appropriation of $300,000 to continue to Poison Control Center until December 31, 1999. To address the long-term need for a statewide Poison Control Center, HEALTH's Division of Family Health (DFH) issued a regional RFP in partnership with the Massachusetts Department of Health. The new Regional Poison Control Center is housed in the Boston Children's Hospital, and it receives an average of 4,500 calls a month with 13% of the calls coming from Rhode Island. The DFH will continue to focus its efforts in this area on the provision of quality poison control services with a strong emphasis on prevention and outreach to under-served populations. To this end, the Center has hired a full-time health educator who will spend two to three days per week in Rhode Island. In addition, a newly established Advisory Committee, with representatives from both states, has met twice and has established two workgroups to address quality and education issues. The Regional Center is currently recruiting a Director to oversee the center's administrative operations.

The DFH is also in the process of developing an electronic network of parents that will serve as an information sharing and networking tool. The network, Ocean State Coalition, focuses on linking families to each other and providers through the Internet. The groundwork for the Ocean State Coalition, which is coordinated by the Rhode Island Parent Information Network (RIPIN), began in mid-1999 with a network of parents, technical support associations, professional organizations, schools, state agencies and Hasbro Children's Hospital. The DFH's SSDI Initiative has enabled the Ocean State Coalition to accelerate its work and to leverage other funds from the Rhode Island Department of Education and Family Voices. The Ocean State coalition will initially target low-income families with CSHCN and children at-risk for developmental delay. It will begin in one racially/ethnically diverse neighborhood in Providence on a pilot basis. Families will be recruited through schools, local community agencies, COZ Family Centers, and two local hospitals. RIPIN has hired a project coordinator who will implement a plan to put computers into the homes of participating families. Early commitments of hardware have been received from a variety of state and private sources.

4.3 Public Input

Application Development

As a way to facilitate public input during the development of the state's Title V plan for 2001, the Division of Family Health (DFH) held a public hearing on Friday, June 16, 2000, from 10:00 a.m.-12:00 noon, in the Rhode Island Department of Health's (HEALTH's) Auditorium. A notice for the hearing was placed in the state's single statewide newspaper, the Providence Journal-Bulletin. Twenty-two individuals from the community attended the hearing, in addition to one parent-consumer and several DFH management staff. Agencies represented included the Cranston COZ Family Center, St. Joseph Hospital's Providence Smiles Program, Children's Friend & Service, R.I. Youth Guidance, the Minority Health Advisory Council, Central Region Early Intervention, Kent

County Mental Health Center, RI KIDS COUNT, Pawtucket COZ Family Center, Family Voices Rhode Island, CHISPA, Warrior Women, Thundermist Health Center, Youth In Action, and VNS of Newport.

The majority of the individuals who attended expressed their belief that the DFH's programs are valuable core public health investments dedicated to improving the health and well being of families throughout the state. Many of the individuals who attended were concerned that several of the DFH's programs need continued or expanded investments. The School-Based Health Centers (SBHCs) need about $600,000 in additional funding to support the program after the end of Robert Wood Johnson (RWJ) funding, Adolescent Health needs more resources to give teens and adults the skills and supports to help teens succeed, Women's Health Screening & Referral needs more resources to strengthen the state's existing continuum of services for women, Home Visiting needs substantial additional funding to provide all eligible families with support, and Immunization needs $2-3 million for new vaccines and public education. Several of the individuals who attended provided testimony advocating for expanded investments for these programs.

Robert Wooler, of Rhode Island Youth Guidance, stated that the DFH's Home Visiting Program "is more than just an outreach program – it is the glue that holds all early childhood programs and urban communities in the state together" and that "it represents the lifeline to other community services and in the process, provides critical coordination, leadership, innovation, cultural competence, and access in trying to make services work for families and children". Parent Michelle Phillips stated that "the only way that she got through the many problems that she had with her children's health was with the help of the DFH's home visitors, who came to my home – not only to let me know how my children were doing – but to see if we had enough food, enough clothing, furniture…..I think the home Visiting Program is absolutely wonderful, and I felt that it was very important for me to come here today and tell you so in person". Brenda Whittle, of Thundermist Health Center, stated that the DFH's home visitors "are the eyes and ears and educators for primary care providers about what is going on in a child's home – I can't tell you how important it is for families to have a nurse in the home listening, understanding, and sharing, and then bringing that information back to the child's pediatrician".

Mary Parella, of the Pawtucket COZ, stated her support for increased funding for SBHCs and Karen Feldman, of Youth in Action, urged the DFH to expand its current investments in activities that promote youth leadership and youth development. Christine Vallee, of the Providence Smiles Program, expressed her belief that enhance funding is needed for children's oral health, which is in crisis. Dawn Wardyda, of Family Voices Rhode Island expressed her support for the DFH's parent involvement CSHCN child care activities. Luisa Murillo, of the Minority Health Advisory Council, expressed a desire to see more attention given to the health-related needs of immigrants. Others stated that the implementation of community systems development partnerships and the utilization of "Promotoras" in ethnically diverse communities are valuable investments that should continue. Many of the individuals who provided testimony at the hearing also advocated for enhanced support for key DFH activities through other channels, including the state legislature. Several individuals who participated commented favorably on the documents that were distributed as handouts by the DFH for the hearing (See Page 207). The documents were perceived as being "consumer-friendly" and "easy to understand".

Title V Implementation and Evaluation

The DFH believes that the organized efforts of several community advocates are influencing planning in several key programmatic areas. The Immunization Program will increase existing insurance assessment fees to support new vaccines and its health education activities, and increased state legislative support for SBHCs is looking hopeful. urgent planning, including higher reimbursement rates, for the Home Visiting Program is expected to take place over the next few weeks, and the DFH hopes that the combination of Medicaid changes, Early Intervention improvements, and the comprehensive newborn screening strategy might address basic problems with home visiting. In addition, a new RFP will allow the DFH to expand and strengthen the Parent Consultant Program in the fall.

4.4 Technical Assistance

See Form 15 in Supporting Documents Section 5.8.

SUPPORTING DOCUMENTS

5.1

GLOSSARY

5.1 Glossary

Adolescent Self-Sufficiency Program: Administered by the Rhode Island Department of Human Services (DHS), the Adolescent Self-Sufficiency Program provides pregnant and parenting teens with an array of culturally competent, community-based services as a way to prevent additional pregnancies.

Administration of Title V Funds: The amount of funds the State uses for the management of the Title V allocation. It is limited by federal statute to 10 percent of the federal Title V allotment.

Assessment: See "Needs Assessment".

Capacity: Program capacity includes service delivery systems, workforce, policies, and support systems (e.g. training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and materials resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcomes, and risk factors. Program capacity results should answer the question "What does the State need to achieve the results we want?"

Capacity Objectives: Objectives that describe the improvement in the ability of the program to deliver servcies or affect the delivery of services.

Care Coordination Services For Children with Special Health Care Needs (CSHCN): Those servcies that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for CSHCN and their families [See Title V Section. 501 (b) (3)].

Carryover (As used in forms 2 & 3): The unobligated balance from the previous year's federal Title V allocation.

Case Management Services: For pregnant women, those services that assure access to quality prenatal, delivery, and post-partum care. For infants up to age one year, those services that assure access to quality preventive and primary care services [See Title V Section 501 (b) (4)].

CEDARR Initiative: The CEDARR (Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Reevaluation) Initiative defines a set of culturally competent, family-centered coordinated system of services for CSHCN, which will be purchased by the Rhode Island Department of Human Services (DHS). The services available through the CEDARR Initiative will serve to significantly enhance the range and quality of services available to CSHCN and their families throughout the state.

Child Care Support Network (CCSN): Funded by the Rhode Island Department of Human Services (DHS) and the Rhode Island Department of Health's (HEALTH), the CCSN provides intensive training and technical assistance to 150 child care providers throughout the state. Two of the CCSN-funded agencies are located in the racially/ethnically diverse urban communities of Providence and Woonsocket and the third is located in the high need "rural" South County area. The CCSN is expected to increase the number of child care providers its serves to 250 in 2001.

Child Find: One of the major objectives of the state's Early Intervention Program is to identify all children eligible for early intervention services. In order to achieve this objective, the state has implemented a system, called Child find, that employs three methods concurrently on a statewide basis to identify eligible children. The three methods utilized are universal screening, direct referrals, and public awareness. Child Find efforts are coordinated with all state agencies, including the state Department of Education; the Rhode Island Department of Health (HEALTH); and the Department of Human Services (DHS).

Child Opportunity Zone (COZ): As a part of its statewide education reform efforts, the state supports Child Opportunity Zones (COZs) to provide critical early childhood and basic human services needs to children ages birth to five and their families. Community services available to families with young children

are new and fragmented. COZs are a comprehensive, family-centered approach that forges linkages among existing community programs and services through Family Centers.

Children: A child from age one year through the 21rst year, who is otherwise not included in any other class of individuals.

CHILDSPAN: Funded by the Rhode Island Department of Human Services (DHS), CHILDSPAN is the community-based agency designated by the state to provide training to child care providers throughout the state. The community-based agency Children's Friend and Service administer CHILDSPAN.

Children's Cabinet: Created by the Governor, the Children's Cabinet is made up of the directors of state government that administer programs for children (i.e. The Departments of Health; Education; Human Services; and Children, Youth & Families). The Children's Cabinet has been charged with developing and coordinating effective children's policies and programs in Rhode Island. The Children's Cabinet reports directly to the Governor.

Children with Special Health Care Needs (CSHCN): For budgetary purposes, infants and children from birth through the 21rst year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basis care, including children with or at risk of disabilities, chronic illnesses and conditions, and health-related education and mental/behavioral problems. For planning and systems development, those children who have or are at increased risk for chronic physical, developmental, or mental/behavioral conditions and who also require health and related services of a type or amount beyond that required by children generally.

Classes of Individuals: Authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women", "Infants", Children with Special Health Care Needs (CSHCN)", "Children", and "Others".

Community: A group of individuals living as a smaller social unit within the confines of a lager one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-Based Care: Services provided within the context of a defined community.

Community-Based Service System: An organized network of services that are grounded in a plan developed by a community and that is based on needs assessment.

Coordination: See "Care Coordination".

"Core" Communities: Five (5) of Rhode Island's 39 communities have the highest rates of poverty, drop-outs, serious crimes, births to single mothers, minority populations, teenage births, and single female-headed households. These 5 communities are referred to as the state's "core" communities, and they include Providence, Woonsocket, Pawtucket, Central Falls, and Newport.

Culturally Sensitive: The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences, and the development of approaches to health care with those differences in mind.

Culturally Competent: The ability to provide services to clients that respect different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multi-cultural staff and other resources in the policy development, administration, and provision of those services. Used interchangeably with "culturally appropriate".

Danforth Policymakers Group: The Danforth Policymakers Group is a group of government (executive & legislative) and community leaders who were chosen to participate in a statewide children's policy retreat sponsored by the Rhode Island Department of Education in 1998 and 1999.

Deliveries: Women who received a medical care procedure associated with the delivery of a live birth or the expulsion of a fetal death (gestation of 20 weeks or greater).

Direct Health Services: Those services generally delivered on a "one-to-one" basis between a health care provider and a patient in an office, clinic, or emergency room. Basic servcies include what most consider to be ordinary medial care, inpatient and outpatient servcies, allied health servcies, drugs, laboratory testing, x-ray servcies, dental care, and pharmaceutical servcies.

Enabling Services: Services that allow or provide for access to and the derivation of benefits from the array of basic health care services, which includes such things as transportation, translation servcies, family support services, etc.

Family-Centered Care: A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal Allocation (As it applies to the Application Face Sheet [SF 424] and Forms 2 & 3): The funds provided to the State under the federal Title V Block Grant in any given year.

Government Performance & Results Act (GPRA): Federal legislation enacted in 1993 that requires federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System: The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services, and providers**.**

Individual Education Plan (IEP): The state requires that all children in special education have an IEP, which is a written statement for a child with a disability that is developed, reviewed, and revised in meetings in accordance with the state's existing Special Education regulations.

Individual Family Service Plan (IFSP): The state's Early Intervention Program assures that each eligible child and family receive evaluation and assessment, service implementation, service coordination, and procedural safeguards. For each child evaluated for the first time and deemed eligible for early intervention services, an IFSP is prepared no later than 40 days after referral. The IFSP must be developed jointly by the family and qualified personnel providing early intervention services. Each IFSP is based on the multi-disciplinary evaluation and assessment of the child and family and includes services necessary to enhance the development of the child and the capacity of the family to meet the needs of the child.

Infants: Children under one year of age not included in any other class of individuals.

Infrastructure Building Services: The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health service standards/guidelines, training, data and planning systems.

Local Funding: (As used in Forms 2 & 3): Those funds deriving from local jurisdictions within the State that are used for maternal and child health program activities.

Low-Income: An individual of family with an income determined to be below the income official poverty line defined by the federal Office of Management & Budget and revised annually in accordance with Section 673 (2) of the Omnibus Budget Reconciliation Act of 1981 [Title V Section 501 (b) (2)].

MCH Pyramid of Health Servcies: See "Types of Services".

Measures: See "Performance Measures".

Medical Home: The linkage of a child with an identified primary care provider is considered to be a medical home for that child. A child's medical home can include linkage of a CSHCN with a specialty or subspecialty care provider, as appropriate.

Natural Setting: Natural setting means to the maximum extent appropriate to the needs of CSHCN. CSHCN services must be provided in natural environments, including the home and community settings in which children without disabilities participate.

Needs Assessment: A study undertaken by an entity to determine the service requirements within a jurisdiction. For maternal & child health purposes, the study is aimed at determining 1) what is essential in terms of the provision of health services, 2) what is available, and 3) what is missing.

Objectives: The yardsticks by which an agency can measure its efforts to accomplish a goal. See also "Performance Objectives").

Other Federal Funds (Forms 2 & 3): Federal funds other that federal Title V Block Grant funds that Are under the control of the State Title V Program.

Others (As in forms 4, 7, & 10): Women of childbearing age, over 21 years of ages, and any others as defined by the State and not otherwise included in any other class of individuals.

Outcome Objectives: Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure: The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievements of health outcome. Health outcome results are usually longer term and tied to the program's ultimate goal. Outcome measures should answer the question "What does the State Program do?".

Performance Indicator: The statistical or quantitative value that expresses the result of a performance measure.

Performance Measure: A narrative statement that describes a specific maternal and child health need, or requirement, that, when successful addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally, within a specified time frame.

Performance Measurement: The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objective: A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population-Based Services: Preventive interventions and personal health services developed and available for the entire MCH population of the State, rather than for just individuals in a one-to-one situation. Disease prevention, health promotion, and statewide outreach are major population-based activities.

Pregnant Woman: A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Servcies: Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care: The provision of comprehensive personal health servcies that include health maintenance and preventive servcies, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individuals' health care services**.**

Process: Process results are indicators of activities, methods, and interventions that support the achievement of outcomes. A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term that results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome.

Process Objective: The objectives for activities and interventions that drive the achievement of higher level objectives.

Program Income (As used in the Application Face Sheet [SF 424] and Forms 2 & 3): Funds collected by the State Title agencies from sources generated by the State Title V Program. These funds include insurance payments and Medicaid reimbursements.

Rhode Island Safe Kids Coalition: The Rhode Island Safe Kids Coalition is part of the National Safe Kids Campaign, the only national organization dedicated solely to the prevention of unintentional childhood injuries in children ages 14 and younger. There are more than 240 state and local Safe Kids Coalitions in all 50 states, the District of Columbia, and Puerto Rico.

Risk Factor Objectives: Objectives that describe an improvement in risk factors (usually mental or behavioral) that cause morbidity and mortality).

Risk Factors: Public health activities and programs that focus on reduction of scientifically established direct causes of and contributors to morbidity and mortality (i.e. risk factors) are essential steps toward achieving health outcomes. Changes in mental and behavioral conditions are the indicators of achievement of risk factors results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question "Why should the State address this risk factor?".

Service Coordination: Service coordination means the activities carried out by a service coordinator to assist and enable a child eligible for early intervention services and the child's family to receive the rights, procedural safeguards, and services authorized under the state's Early Intervention Program.

State: As used in this application, the State of Rhode Island & Providence Plantations**.**

State Funds (As used in Forms 2 & 3): The State required matching funds (including overmatch) in any given year.

Systems Development: Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance: The process of providing recipients with expert assistance of specific health related or administrative servcies that include: systems review planning, policy options analysis, coordination, coalition building, training, data systems development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development & evaluation, public health/managed care quality standards development, public and private interagency integration and identification of core public health issues.

Title XIX: With resect to the number of infants entitled to XIX, the unduplicated count of infants who were eligible for the State's Title XIX (Medicaid) Program at any time during the reporting period. With respect to the number of Pregnant women entitled to Title XIX, the unduplicated number of pregnant

women who delivered during the reporting period who were eligible for the State's Title XIX (Medicaid) Program**.**

Title V: With respect to the number of deliveries to pregnant women served under Title V, the unduplicated number of deliveries to pregnant women who were provided with prenatal, delivery, or post-partum servcies during the reporting period. With respect to the number of infants enrolled under Title V, the unduplicated number of infants provided a direct service by the State's Title V Program during the reporting period.

Total MCH Funding: All of the Title V funds administered by the State Title V Program, which is made up of the sum of the federal Title V Block Grant allocation, the Applicant's funds (carryover from the previous year's federal Title V Block Grant allocation), the State's funds (the total matching funds for the Title V allocation-match & overmatch), local funds (total of MCH dedicated funds from local jurisdictions within the State), Other federal funds (funds other than federal Title V Block grant funds), and Program income (insurance payments and Medicaid reimbursements).

Types of Services: The major kinds or levels of health care servcies covered under Title V activities. See "Direct Services", "Infrastructure Building Services", "Enabling Services", and "Population-Based Services".

SUPPORTING DOCUMENTS

5.2

ASSURANCES & CERTIFICATIONS

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain,

or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight

Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law

also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

SUPPORTING DOCUMENTS

5.3

OTHER SUPPORTING DOCUMENTS

SUPPORTING DOCUMENTS

5.4

CORE HEALTH STATUS INDICATOR FORMS

SUPPORTING DOCUMENTS

5.5

CORE HEALTH STATUS INDICATOR DETAIL SHEETS

SUPPORTING DOCUMENTS

5.6

DEVELOPMENT HEALTH STATUS INDICATOR FORMS

SUPPORTING DOCUMENTS

5.7

DEVELOPMENTAL HEALTH STATUS INDICATOR DETAIL SHEETS

SUPPORTING DOCUMENTS

5.8

ALL OTHER FORMS

SUPPORTING DOCUMENTS

5.9

NATIONAL “CORE” PERFORMANCE MEASURE DETAIL SHEETS

SUPPORTING DOCUMENTS

5.10

STATE “NEGOTIATED” PERFORMANCE MEASURE DETAIL SHEETS

SUPPORTING DOCUMENTS

5.11

OUTCOME MEASURE DETAIL SHEETS